



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



FMSHK

Annual Scientific Meeting 2026

Empowering Progress: Innovation, Integration, Impact

28 JUNE
2026 — (SUN)
Physical

09:00 - 17:05

The Ballroom, 7/F, Cordis, Hong Kong
(555 Shanghai Street, Mongkok, Kowloon)

Programme Book



forxiga
(dapagliflozin)

ONCE-DAILY
xigduo XR
(dapagliflozin/metformin HCl
extended-release) tablets

LIVE BETTER, LONGER

FORXIGA - your choice of
SGLT2i with mortality benefits
in CKM management^{1*}

CKD:

Forxiga reduces
kidney function decline, ESKD,
and renal or CV death

↓ 39%²
RRR

vs placebo
(HR 0.61 (95% CI:0.51, 0.72);
P<0.001; N=4304)

Heart failure:

Forxiga reduces time to the
first occurrence of hospital
admission for worsening HF or
death from CV causes **across**
the range of EF³

↓ 22%³
RRR

vs placebo
(HR 0.78 (95% CI 0.72–0.86);
P < 0.001)

T2D:

Xigduo XR provides powerful
glycaemic control
in **once daily combination**

↓ 1.9%⁴

HbA1C from baseline

*Forxiga (dapagliflozin) is indicated for chronic kidney disease, heart failure and type 2 diabetes

CI=Confidence interval; CKD=Chronic kidney disease; CKM=Cardiovascular-kidney-metabolic; CV=Cardiovascular; EF=Ejection fraction; ESKD=End-stage kidney disease; HbA1C=Glycated Hemoglobin; hHF=hospitalization for heart failure; HF=heart failure; HR=Hazard ratio; RRR=Relative risk reduction; SGLT2i=sodium-glucose co-transporter 2 inhibitors; T2D=Type 2 diabetes.

References: 1. Forxiga Hong Kong Prescribing Information December 2023. 2. Heerspink HJL, et al. N Engl J Med. 2020 Oct 8;383(15):1436-1446. 3. Jhund PS, et al. Nat Med. 2022;28(9):1956–1964. 4. Henry RR, et al. Int J Clin Pract. 2012 May;66(5):446-56.

Intended for Healthcare professionals only.

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

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HK-11317 (03/2025)

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FORXIGA



XIGDUO XR





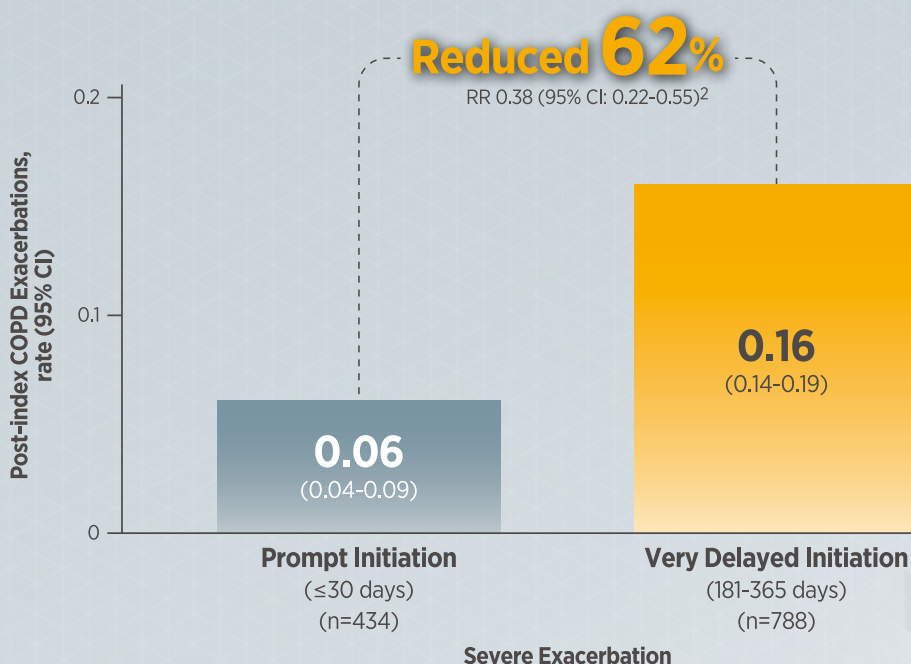
BREZTRI
AEROSPHERE™

(budesonide, glycopyrronium, and
formoterol fumarate) Inhalation Aerosol

Prompt initiation of **BREZTRI** after an exacerbation reduced the risk of subsequent severe exacerbations^{1,2}



Reduction of severe exacerbations^{1,2}



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%).³

Study Design:

The EROS (Exacerbation and Real-World Outcomes) Study is a retrospective observational analysis of a real-world closed claims database. The study assessed the impact of prompt initiation of BREZTRI after an index exacerbation event in 2409 patients. This analysis used US claims data from patients <40 years old with COPD who initiated BREZTRI after >1 severe exacerbation, >2 moderate exacerbations, or >1 moderate exacerbation while on other maintenance treatment. The index date was the earliest exacerbation event occurring prior to Breztri initiation but after the approval of Breztri in the US (July 24, 2020). In the 12-month period following the index exacerbation, all patients were required to have >1 pharmacy claim for BREZTRI. The timing of the initiation of BREZTRI from the index exacerbation was classified as prompt if it was within 30 days, delayed if between 31 and 180 days, and very delayed if between 181 and 365 days. The primary outcomes were the rate of COPD exacerbations and healthcare costs for those that received BREZTRI promptly versus delayed and very delayed. A moderate exacerbation was defined as an outpatient visit with a COPD diagnosis followed by a filled prescription of short course of oral corticosteroids or antibiotics claim within <7 days of the visit, or any outpatient visit with COPD diagnosis and a corticosteroid injection. A severe exacerbation was an inpatient hospitalization with a primary diagnosis of COPD or a primary diagnosis of respiratory failure with a secondary diagnosis of COPD.

During the baseline period, overall 62.7% had fixed combination of ICS/LABA and 19.1% had fixed LABA/LAMA combination.

The rate (95% CI) of total exacerbations post-index increased as time to BGF initiation increased: prompt 1.52 (1.39-1.66); delayed 2.00 (1.92-2.09); and very delayed 2.30 (2.20-2.40). Relative rates of total exacerbations for prompt were 0.76, 95% CI: (0.69 - 0.83) and 0.66, 95% CI: (0.60 - 0.72) versus delayed and very delayed.^{1,2}

BGF = budesonide/glycopyrrolate/formoterol; CI = confidence interval; COPD = chronic obstructive pulmonary disease; ICS/LABA = budesonide / formoterol fumarate dihydrate; LABA/LAMA = glycopyrronium / formoterol fumarate dihydrate; RR = relative rate; US = United States.

References: 1. Strange C, et al. International Journal of Chronic Obstructive Pulmonary Disease. 2023;18: 2245-2256. 2. Erratum: Exacerbations and Real-World Outcomes After Single-Inhaler Triple Therapy of Budesonide/Glycopyrrolate/Formoterol Fumarate, Among Patients with COPD: Results from the EROS (US) Study [Corrigendum]. Int J Chron Obstruct Pulmon Dis. 2024;19:1799-1800. Published 2024 Aug 6. doi:10.2147/COPD.S484253 3. BREZTRI Aerosphere, Hong Kong Summary of Product Characteristics, Version Oct 2022.

Abbreviated Prescribing Information

Presentation: Aerosphere pressurised inhalation, suspension budesonide 160 µg/glycopyrronium 7.2 µg/formoterol fumarate dihydrate 5 µg 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, 12-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 CYP3A4 inhibitors, itraconazole, cimetidine, not recommended other anticholinergic and/or long-acting beta2-adrenergic agonist. Other beta-adrenergic, xanthine derivatives, steroids and non-potassium sparing diuretics, beta-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. API HK BRE.1022**

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Further information is available on request.

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HK-12343 23/10/2025

PROGRAMME ►

TIME	PROGRAMME
09:00 - 09:30	Onsite Reception
09:30 - 10:00	Opening Ceremony
10:00 - 10:30	Session 1 <i>Chairperson: Prof. Bernard Man-yung CHEUNG</i> Use of AI in Medicine Dr. Kenneth TSANG <i>Honorary Clinical Associate Professor of School of Public Health, Li Ka Shing Faculty of Medicine of The University of Hong Kong</i>
10:30 - 10:45	Tea Break
10:45 - 11:45	Session 2- AstraZeneca Session <i>Chairpersons : Dr. Chun-kong NG & Dr. Samuel Ka-shun FUNG</i> Managing One Airway: Optimizing Treatment across Asthma, COPD and their Overlaps Dr. John Yu-hong CHAN <i>Specialist in Respiratory Medicine</i> Prioritizing Renal Risk: Repositioning Kidney Protection as Core Prevention in DKD Dr. Simon Chi-yuen CHEUNG <i>Specialist in Nephrology</i>
11:45 - 12:45	Session 3 <i>Chairpersons: Dr. Jane Chun-kwong CHAN & Ms. Ellen Wai-yin KU</i> Current Prenatal Genetic Screening and Diagnosis Dr. Kwok-yin LEUNG <i>Specialist in Obstetrics & Gynaecology</i> Acute Hemorrhoidal Complications: Evidence-based Intervention and Update of Non-excisional Therapy Dr. Lik-hang LEUNG <i>Specialist in General Surgery</i>
12:45 - 13:45	Lunch Symposium <i>Chairpersons: Dr. Kingsley Hau-ngai CHAN & Dr. Alson Wai-ming CHAN</i> Topical JAKi in the Management of Skin Disease Dr. Davis Yung CHAN <i>Specialist in Dermatology and Venereology</i> Targeting the IL-4/IL-13 Pathway in Dermatology: A Multidisciplinary Approach Dr. Martin Man-ho CHUNG <i>Specialist in Dermatology and Venereology</i>



PROGRAMME ►

TIME	PROGRAMME
13:45 - 14:45	Session 4 <i>Chairpersons: Dr. Siu-pui LAM & Dr. Desmond Gia-hung NGUYEN</i> Adult Pneumococcal Disease Prevention in Hong Kong and the Next Generation Pneumococcal Conjugate Vaccine Dr. Daniel Wai-sing CHU <i>Specialist in Family Medicine</i> Central Nervous System Dysmyelinating Disorders in Children Dr. Mario Wai-kwong CHAK <i>Specialist in Paediatrics</i>
14:45 - 15:45	Session 5 <i>Chairpersons: Dr. Samuel Ka-shun FUNG & Dr. Chun-kong NG</i> The Biology of Obesity: Anti-Obesity Medications and the Challenge of Weight Regain Dr. Johnny Yau-cheung CHANG <i>Specialist in Endocrinology, Diabetes & Metabolism</i> Transformative Survival in Lung Cancer, the Power of Personalized Medicine, Targeted Drug Discovery and Immunotherapy Dr. Roland Ching-yu LEUNG <i>Specialist in Medical Oncology</i>
15:45 - 16:00	Tea Break
16:00 - 17:00	Session 6 <i>Chairpersons: Dr. Victor Hip-wo YEUNG & Dr. Kwai-ming SIU</i> Development of eHealth+ Ms. Erica Bing-bing LAM <i>Principal Assistant Secretary for the Health Bureau</i> Panel Discussion
17:00 - 17:05	Closing Remarks by <i>Chairpersons: Dr. Victor Hip-wo YEUNG & Dr. Kwai-ming SIU</i>

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WELCOME MESSAGE FROM THE PRESIDENT ►



Prof. Bernard Man-yung CHEUNG

President, the Federation of Medical Societies of Hong Kong

Distinguished guests, esteemed colleagues, and dear friends,

It is with immense pride and joy that I welcome you to the Annual Scientific Meeting of the Federation of Medical Societies of Hong Kong. Last year, we celebrated the Federation's remarkable 60th anniversary—a milestone that honoured our legacy. This year's gathering marks a fresh chapter, one that looks boldly toward the future.

The theme of this year's meeting, "Empowering Progress: Innovation, Integration, Impact," reflects our unwavering commitment to advancing healthcare through creativity, collaboration, and meaningful change. To these three "I's," I would also add a fourth—Intelligence—for it is through knowledge and insight that innovation truly flourishes.

We are privileged to have assembled a distinguished faculty of experts who will share their wisdom across diverse disciplines. Together, we anticipate a vibrant exchange of ideas and the fostering of a spirit of collaboration that will strengthen our collective pursuit of excellence.

Marie Curie once said, "One never notices what has been done; one can only see what remains to be done." Her words remind us that science is a continuous journey, and that each achievement opens the door to new challenges and discoveries in our shared mission to improve health and well-being.

On behalf of the organizing committee, I extend my warmest welcome to each of you. May this Annual Scientific Meeting be enlightening, inspiring, and truly memorable. Thank you.

WELCOME MESSAGE FROM THE CHAIRPERSONS ►



Dr. Kingsley Hau-ngai CHAN

Co-Chairman, Annual Scientific Meeting 2026

EXCO Member, the Federation of Medical Societies of Hong Kong

Welcome to the Federation of Medical Societies of Hong Kong Annual Scientific Meeting 2026. As highlighted by our main theme: **Empowering Progress: Innovation, Integration, Impact**, the meeting reflects the rapid evolution of modern medicine. We gather at a pivotal moment where technological breakthrough meets clinical practice. We are honored to host a stellar lineup of experts to share invaluable insights through the meeting today.

From AI-driven clinical decision support systems to predictive analytics in public health, smart technology is no longer a future concept—it is actively reshaping our daily practice. We will explore how local clinicians are integrating AI to enhance diagnostic accuracy, optimize workflows, and ultimately deliver safer, more precise patient care across the territory.

Thank you to our organizing committee, sponsors, and member societies for their tireless dedication. Most importantly, thank you to each of you for your unwavering commitment to medical excellence. May this meeting inspire new ideas, strengthen professional bonds, and empower progress across all our specialties.

A handwritten signature in black ink, appearing to read 'Kingsley Chan'.



WELCOME MESSAGE FROM THE CHAIRPERSONS ►



Dr. Siu-pui LAM

Co-Chairman, Annual Scientific Meeting 2026

EXCO Member, the Federation of Medical Societies of Hong Kong

Welcome to the Annual Scientific Meeting 2026 of the Federation of Medical Societies of Hong Kong.

The theme of this year is “**Empowering Progress: Innovation, Integration, Impact**”. In the era where innovation in scientific knowledge and technologies, artificial intelligence and personalized medicine is unprecedented, it is crucial for healthcare professionals to integrate the advances into multi-disciplinary care. The success is measured by the translation in development in modern medicine into clinical benefits of patient centre care.

This year, our sessions are specifically designed to bridge the gap between innovation and practical, clinical application. We are extremely honoured to have experts from different specialists to share with us the latest clinical knowledge and skills through a series of lectures. We hope that you find the topics stimulating and interesting and will be beneficial to your clinical practice.



SHINGRIX
(ZOSTER VACCINE
RECOMBINANT, ADJUVANTED)

GSK

NEW GENERATION VACCINE to PREVENT SHINGLES

INDICATED FOR¹

18+ : **50+**
YEARS OLD : YEARS OLD
WITH INCREASED RISK

≥ 90%
EFFICACY^{1A}

Long-term protection
of Shingrix reached*

87.7%²
(95% CI: 84.9-90.1)

Efficacy lasts for

11 YEARS²

HZ = Herpes zoster
HZV = Herpes zoster vaccine

¹ Efficacy adults aged 50 years or above

² Study design: ZOSTER-049 is a phase III open-label, long-term follow-up trial from two pivotal phase III randomised clinical trials (ZOE-50, ZOE-70). The trial evaluated the efficacy, safety, and immunogenicity in adults 50 years and over at time of vaccination, for six additional years after completion of the ZOE-50 and ZOE-70 trials, up to approximately 11 years of follow-up. ZOSTER-049 included over 7,000 participants from 18 countries across five continents, with vaccine recipients compared to historical controls. From 1 month after the second dose of Shingrix, the vaccine efficacy was 87.73% (95% CI: 84.9-90.1).

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



References: 1. GlaxoSmithKline, Shingrix Hong Kong Prescribing Information, GD506.
2. Abstract: Strezova A. ECCMID; 2024; 1-5.

Indication statement¹:

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

Safety information

Shingrix has clinically acceptable safety and tolerability profile. Contraindications:
Hypersensitivity reactions to the active substances or other components of the vaccine.

Adverse reactions:

Local reactions at the injection site (pain, redness, swelling, itching) and systemic symptoms such as headache, gastrointestinal symptoms, muscle and joint pain, fatigue, shivering, fever, malaise. You are advised to read the full safety information in the Shingrix Full Prescribing Information before prescribing.

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

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PM-HK-SGX-PSTR-240008(09/2026) Date of preparation: 10 Oct 2024

Release from
bronchoconstriction
Empowering every breath

TRELEGY is
APPROVED
for Adult
Asthma!^{*1,2}



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).

Abbreviations: ICS: inhaled corticosteroid; LABA: long-acting β_2 -agonist; LAMA: long-acting muscarinic antagonist.

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Please read the full prescribing information prior to administration. Full prescribing information is available upon request. For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong), or send an email to us at HKAdverseEvent@gsk.com.

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PM-HK-FVU-PSTR-230001 (08/2026) Date of preparation: 01/09/2024

Prescribing Information:



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



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

CONGRATULATORY MESSAGES ▶



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The Chief Executive

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專才博匯
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醫務衛生局局長盧寵茂



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匯賢博議
弘健惠民

醫務衛生局副局長范婉雯





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Director of Health

賢醫博議
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衛生署署長林文健



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Legislative Council Member

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立法會議員 林哲玄 醫生



敬賀



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Prof. Philip Kam-tao Li

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香港醫學組織聯會二零二六年週年科研大會

集賢匯智
醫理拓新

香港醫學專科學院主席李錦滔教授

李錦滔

CONGRATULATORY MESSAGES ▶



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

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醫研創新
惠澤群倫

醫院管理局主席范鴻齡





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Chief Executive, Hospital Authority

研創致遠
共致宏效

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醫院管理局行政總裁李夏茵



CONGRATULATORY MESSAGES ▶



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Dean of Medicine, School of Clinical Medicine, The University of Hong Kong

香港醫學組織聯會二零二六年周年科研大會

醫道惟新
融通致遠

香港大學副校長（健康）
李嘉誠醫學院院長劉澤星



謹賀



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Dr. Hon Wing-man KO, GBS, JP
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醫護同心
守護民康

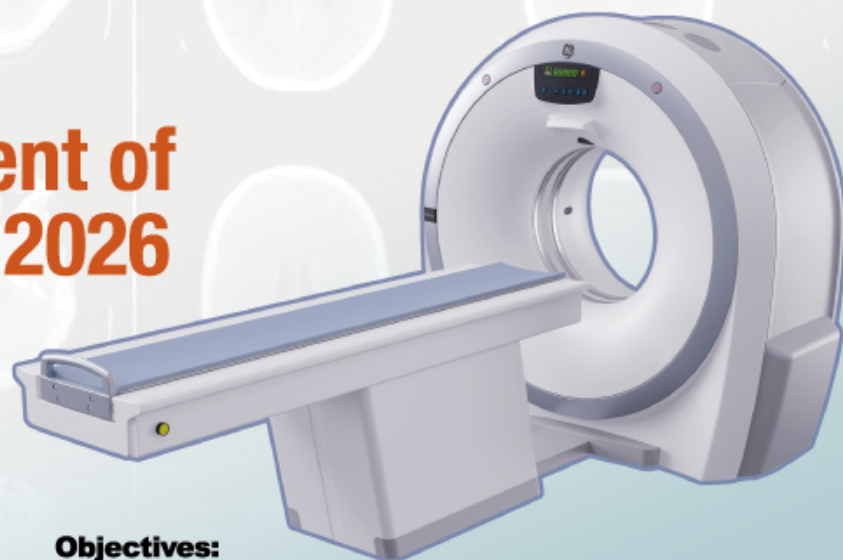
梁智鴻

● Course No. C437 ● CME/CNE Course

Certificate Course on

Latest Advancement of Nuclear Medicine 2026

(Video Lectures)



Jointly organised by



The Federation of Medical Societies of Hong Kong



Hong Kong Society of Nuclear Medicine and Molecular Imaging

Objectives:

Designed for Nuclear Medicine Physicians, Radiologists, Clinical Oncologists, Nurses and Radiographers, this course offers latest updates in Nuclear Medicine and PET/CT. Through six focused lectures, participants will understand the advancements in Nuclear Medicine and PET/CT diagnosis and therapy – both in Oncology and beyond.

Date	Topics	Speakers
9 July 2026	Nuclear Cardiology and Radiation Safety	Dr. Chan Ka Wai, Gary Associate Consultant Nuclear Medicine Unit Department of Radiology Queen Mary Hospital
16 July 2026	Clinical Applications of Nuclear Medicine in Musculoskeletal System	Dr. Chow Tsz Kit Consultant Department of Radiology & Nuclear Medicine Tuen Mun Hospital
23 July 2026	Clinical Applications of PET in Dementia	Dr. Kwok Sing Hon, Julio Specialist in Nuclear Medicine
30 July 2026	Evolving Therapeutic and Diagnostic (Theranostic) Roles of Nuclear Medicine – Neuroendocrine Neoplasm and More	Dr. Li Wai Ip Associate Consultant Nuclear Medicine Unit Department of Diagnostic and Interventional Radiology Queen Elizabeth Hospital
6 Aug 2026	Clinical Roles of FDG PET/CT in Oncology, Infection and Inflammation	Dr. Tsoi Pak Lai Associate Consultant Department of Nuclear Medicine Pamela Youde Nethersole Eastern Hospital
13 Aug 2026	Clinical Roles of Non FDG PET/CT in Oncology and Beyond	Dr. Yip Yu, Jasmine Specialist in Nuclear Medicine

Date : 9, 16, 23, 30 July and 6, 13 August 2026 (THUR)

Duration of Session : 1.5 hours (6 sessions)

Time : 7:00 pm – 8:30 pm (or within 4 days from each Lecture Date)

Course Feature : Video lectures (with Q&A platform for participants to post the questions)

Language Media : Cantonese (Supplemented with English)

Quiz for CME : DOCTORS are required to complete a Quiz after the completion of each lecture

Course Fee : HK\$1,200

FMSHK Certificate : Awarded to participants with a minimum attendance of 70% (per Lecture and 4 out of 6 Lectures)

Deadline : 2 July 2026

Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong

Tel: 2821 3512 Fax: 2865 0345 Email : toto.chan@fmskhk.org



ACKNOWLEDGEMENT TO SPONSORS ▶

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ABSTRACTS ▶

Session 1



Dr. Kenneth TSANG

*Honorary Clinical Associate Professor, School of Public Health,
Li Ka Shing Faculty of Medicine, The University of Hong Kong*

Dr. Kenneth Tsang leads the development and Drives operational and clinical excellence of IHH's business operations in North Asia which include multi-specialty hospitals, networks of primary, specialist and surgical clinics, as well as ambulatory care centres in Hong Kong and Shanghai.

In conjunction with his regional role, Dr. Tsang heads Gleneagles Hospital Hong Kong as Chief Executive Officer and provides oversight of the clinic network under Gleneagles Healthcare, ambulatory services under Gleneagles MediCentre, Parkway Laboratory Services and Gleneagles PharmaHome in Hong Kong. He also spearheads Gleneagles Clinical Trials Centre which contributes to healthcare innovation and advancement in Hong Kong and nearby regions.

Prior to joining IHH, Dr. Tsang was with the Hospital Authority in Hong Kong for over 25 years, first as a practising physician in Queen Elizabeth Hospital before taking up management roles in patient safety, strategy and service planning, infection control and cluster services at its Head Office.

Dr. Tsang is a Fellow of the Hong Kong Academy of Medicine (Community Medicine), a Fellow of the Hong Kong College of Community Medicine and a Fellow of The Royal Australasian College of Medical Administrators. He is also an Honorary Clinical Associate Professor of School of Public Health, Li Ka Shing Faculty of Medicine of The University of Hong Kong.

Use of AI in Medicine

Artificial intelligence (AI) is rapidly reshaping the practice of medicine, offering new possibilities to enhance diagnostic accuracy, enhance patient safety, improve clinical outcomes and increase operational efficiency. Rather than replacing clinicians, AI serves as a key enabler in enhancing the end-to-end patient journey, and supporting more personalised and preventive care.

AI is now being deployed in real-world clinical settings and integrated across multiple aspects of healthcare systems, from diagnostics and treatment planning to hospital operations and patient engagement, contributing to more streamlined and coordinated care delivery. Scaling AI adoption will be critical to transforming the healthcare industry, enabling innovations to move beyond pilot use cases and deliver tangible clinical and operational impact.

This presentation shares some of the AI use cases and explores the key priorities for advancing AI adoption in healthcare, including the need for effective platforms for translating innovation into real-world clinical solutions, strong data foundations, and robust governance frameworks to build trust and ensure safe use.



ABSTRACTS ▶



Dr. John Yu-hong CHAN

Specialist in Respiratory Medicine

Consultant, Department of Medicine and Geriatrics, Tuen Mun Hospital

Dr. Chan is a Consultant Respiratory Physician working in the public sector in Hong Kong. He obtained his MBBS degree from The University of Hong Kong and completed specialist training in Respiratory Medicine, with overseas training in Australia and Germany. Dr. Chan has extensive experience in airway diseases, interventional pulmonology, and quality and safety leadership. He currently serves as Honorary Secretary of the Hong Kong Thoracic Society and has held key roles in respiratory education, simulation training, and hospital quality and safety initiatives. His clinical and research interests include asthma, COPD, pleural diseases, and airway interventions. He has published in peer-reviewed international journals and is actively involved in postgraduate training and respiratory service development in Hong Kong.

Managing One Airway: Optimizing Treatment across Asthma, COPD and Their Overlaps

Asthma and chronic obstructive pulmonary disease (COPD) remain major causes of morbidity and healthcare utilization in Hong Kong and worldwide. With an ageing population, a persistent smoking burden, optimizing long-term airway management has become increasingly important in both primary and specialist care. Although asthma and COPD are traditionally viewed as distinct entities, they share overlapping pathophysiological mechanisms, clinical features, and therapeutic strategies.

This lecture will first review the local magnitude and burden of asthma and COPD, followed by a practical discussion of their distinguishing features and the central role of lung function testing in diagnosis and monitoring. Recent updates in international guidelines will be highlighted, including the evolving concept of disease stability in COPD and the emerging paradigm of clinical remission in asthma.

Beyond pharmacotherapy, non-drug interventions—particularly smoking cessation, vaccination, pulmonary rehabilitation, and inhaler technique optimization—needs to be addressed. Family doctors play a pivotal role in fostering long-term partnerships and supporting patient adherence. The session will also discuss the appropriate use of inhaled corticosteroids and the role of single-inhaler triple therapy (SITT) in selected patients. Finally, emerging biologic therapies in asthma and selected COPD phenotypes will be briefly reviewed, underscoring the importance of phenotyping, multidisciplinary care, and timely specialist referral.

Through an integrated and patient-centered approach, clinicians can better navigate the continuum between asthma and COPD, optimizing outcomes across the airway disease spectrum.

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[4] Refers to KLV data with over 1,300 parameters used to monitor farm biodiversity.

[5] Based on internal data. Refers to the data in 2024, the amount of organic milk collected from our own organic farms accounted for approximately 1% of the total milk collected from all of our own farms.

[6] Refers to the organic whole milk listed in the list of ingredients is Dutch meadow milk, which meets the production standards for meadow milk, and that cows are free to roam in meadows for at least 120 days per year and at least 6 hours per day.

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

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

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ABSTRACTS ►

Session 2

**Dr. Simon CHEUNG Chi Yuen**

*Consultant, Department of Medicine, Queen Elizabeth Hospital
President, Hong Kong Society of Transplantation*

Dr. Cheung was graduated from the University of Hong Kong and received his nephrology and advanced internal medicine training in Queen Elizabeth Hospital. After overseas training, he received his Doctor of Philosophy in 2009 from Maastricht University in the Netherlands. In 2017, he received Doctor of Medicine from the University of Hong Kong. His research interests include immunosuppressive drugs in kidney transplantation, pharmacogenetics and onconeurology. He has published more than 110 papers in peer-reviewed international and local journals with over 80% being the first or corresponding author. He was the invited speaker and moderator in different globally renowned conferences such as International Congress of the Transplantation Society, Asian Pacific Congress of Nephrology, Congress of the Asian Society of Transplantation and the Asian Transplantation Week. In addition, Dr. Cheung has also served as reviewer for multiple international journals including the Journal of the American Society of Nephrology, American Journal of Transplantation, Transplant International, Nephrology, Dialysis and Transplantation, Nephrology, etc. He won the Outstanding Staff Award in Queen Elizabeth Hospital and Outstanding Team Award in Kowloon Central Cluster in 2011 and 2026 respectively. In addition, he is selected as one of the finalists for Hospital Authority Outstanding Award in Research in 2026.

Dr. Cheung is currently the President of the Hong Kong Society of Transplantation and Program Director in Nephrology Specialty Board in the Hong Kong College of Physicians. In addition, he is also the Consultant and Deputy Chief of Service in the Department of Medicine at Queen Elizabeth Hospital, Hong Kong.

Prioritizing Renal Risk: Repositioning Kidney Protection as Core Prevention in DKD

Diabetic kidney disease (DKD) is generally defined as the presence of chronic kidney disease (CKD) in a patient suffering from diabetes mellitus. This disease entity is clinically important because it can progress to end stage kidney disease (ESKD), as well as increase the risk for cardiovascular events and mortality. Early manifestations of DKD are typically asymptomatic and are usually detected through regular monitoring of albuminuria and eGFR, which enables disease staging and timely intervention before irreversible decline of renal function. General measures include lifestyle modification, adequate blood pressure, glycaemic and lipid control. Beyond agents used for Renin-Angiotensin System (RAS) blockade, sodium-glucose cotransporter-2 inhibitor (SGLT2i) has been shown to reduce the risk of adverse kidney and cardiovascular outcomes in patients suffering from DKD, independent of its glucose-lowering effect. Different studies have shown that SGLT2i can deliver consistent benefits on sustained eGFR decline, progression to ESKD, cardiovascular death, and all-cause mortality across CKD population. Therefore, addition of SGLT2i with optimized RAS blockade can provide a dual-pathway on cardio-renal protection. This lecture will highlight the role of dapagliflozin within this framework, including clinical outcomes across CKD with and without diabetes, and how to translate the clinical data into our daily practice.



ABSTRACTS ►



Dr. Kwok-yin LEUNG

MBBS, MD, FRCOG, FHKAM (O&G), FHKCOG, Cert HKCOG (MFM)

Specialist in O&G

Honorary Clinical Associate Professor, Department of Obstetrics and Gynaecology, The University of Hong Kong

Honorary Clinical Associate Professor, Department of Obstetrics and Gynaecology, The Chinese University of Hong Kong

Current Prenatal Genetic Screening and Diagnosis

Rapid advances in genetic technology in recent years have substantially enhanced our ability in prenatal genetic screening and diagnosis. Major professional societies including American College of Obstetrics and Gynecology (ACOG), Society of Maternal and Fetal Medicine (SMFM), American College of Medical Genetics (ACMG), and International Society of Prenatal Diagnosis (ISPD) recommend offering non-invasive prenatal genetic screening (NIPS) to all pregnant women for screening of the common aneuploidies (trisomies 21, 18, and 13). NIPS with cell-free DNA is the most accurate screening test for the common trisomies (21, 13 and 18) in unselected singleton populations, and those at known increased probability.

ACMG, ACOG and SMFM also recommend offering NIPS to screen for sex chromosome abnormalities (SCA) in singleton pregnancies given its high sensitivity and specificity. Although NIPS can detect rare autosomal trisomies, sub-chromosomal imbalances, microdeletion/duplication syndromes and single-gene disorders (mostly dominant disorders with a high de novo rate or for paternally inherited autosomal dominant pathogenic variants), major professional societies do not recommend routine screening for these abnormalities except 22q11.2 deletion syndrome because of insufficient data regarding performance and clinical utility, and unknown prevalence in the general population.

According to the ISPD, proper counseling should be provided before and after NIPS, and high-risk results should be managed appropriately. After pretest counseling, every woman has the right to opt for or decline prenatal genetic screening and diagnostic testing. Furthermore, first trimester scan at 11-14 weeks' gestation should be offered before NIPS was performed. When scan abnormalities, including fetal nuchal translucency (NT) measurement ≥ 3.5 mm, are detected, invasive prenatal diagnostic testing with chromosomal microarray or fetalseq should be offered to detect abnormalities which cannot be detected by NIPS.

Carrier screening is used to identify women or couples that are at risk of having a child with a severe autosomal recessive or X-linked genetic disorder. ACMG recommends all pregnant women should be offered carrier screening to allow discussion of their risks and consideration of available reproductive options, whereas RCOG do not, as the chance of an affected child is very low. Clinicians should provide adequate pre-test and post-test counselling including the advantages and limitation of carrier screening panels, the chance of residual reproductive risk, and the phenotypic variability.

Prenatal genetic diagnostic testing has evolved, from traditional karyotyping through chromosome microarray (CMA), low pass sequencing to whole exome sequencing (WES)/ whole genome sequencing (WGS). Uses, advantages and disadvantages of various testings in prenatal genomics will be discussed.

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XX
染色體
疾病

染色體疾病

常見的染色體異常疾病種類包括：
染色體三倍體、性染色體異常及染色體微片段缺失/重複。

臨床表現可能有智能障礙、臉部特徵異常、發育缺陷、遲緩等，綜合發生率高達1/800~1/1000。

常見疾病

- 唐氏症 (Trisomy 21)
- 愛德華氏症 (Trisomy 18)
- 巴陶氏症 (Trisomy 13)
- 透納氏症 (45, X0)
- 柯林菲特氏症 (47, XXY)
- 小胖威利症 (15q11-q13)
- 天使症候群 (15q11-13)

建議檢測

- NIFTY
- NIFTY pro+
- NIFTY twins
- NIFTY pro+ twins

單基因
遺傳病

常見疾病

- 努南氏症候群
- 第一型神經纖維瘤病
- 第二型神經纖維瘤病
- 軟骨發育不全症
- 成骨不全症
- 馬凡氏症候群



努南氏症候群



第一型神經纖維瘤病



第二型神經纖維瘤病



軟骨發育不全症



成骨不全症



馬凡氏症候群

引致胎兒
發育異常
及其他疾病

建議檢測

- 顯性單基因遺傳病

NIFTY mono

1 NIFTY pro+ Nifty Pro+ 無創性胎兒染色體異常產前檢測

三倍體綜合症

- ✓ T21唐氏綜合症
- ✓ T18愛德華氏綜合症
- ✓ T13巴陶氏綜合症

罕見常染色體非整倍體

- ✓ 9號染色體三倍體 (T9)
- ✓ 16號染色體三倍體 (T16)
- ✓ 22號染色體三倍體 (T22)

性染色體非整倍體

- ✓ 透納氏綜合症
- ✓ 柯林菲特氏綜合症
- ✓ XXX 染色體綜合症
- ✓ XYY 三體綜合症

其它

- ✓ 92 種染色體微缺失及微重複疾病
- ✓ 額外發現
- ✓ 胎兒性別

2 NIFTY mono Nifty mono 無創性胎兒單基因遺傳病產前檢測

疾病分類

- 多系統綜合症
- 神經系統疾病
- 骨骼系統疾病
- 顱縫早閉症候群
- 努南氏症候群
- 肌肉相關疾病

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和綜合症



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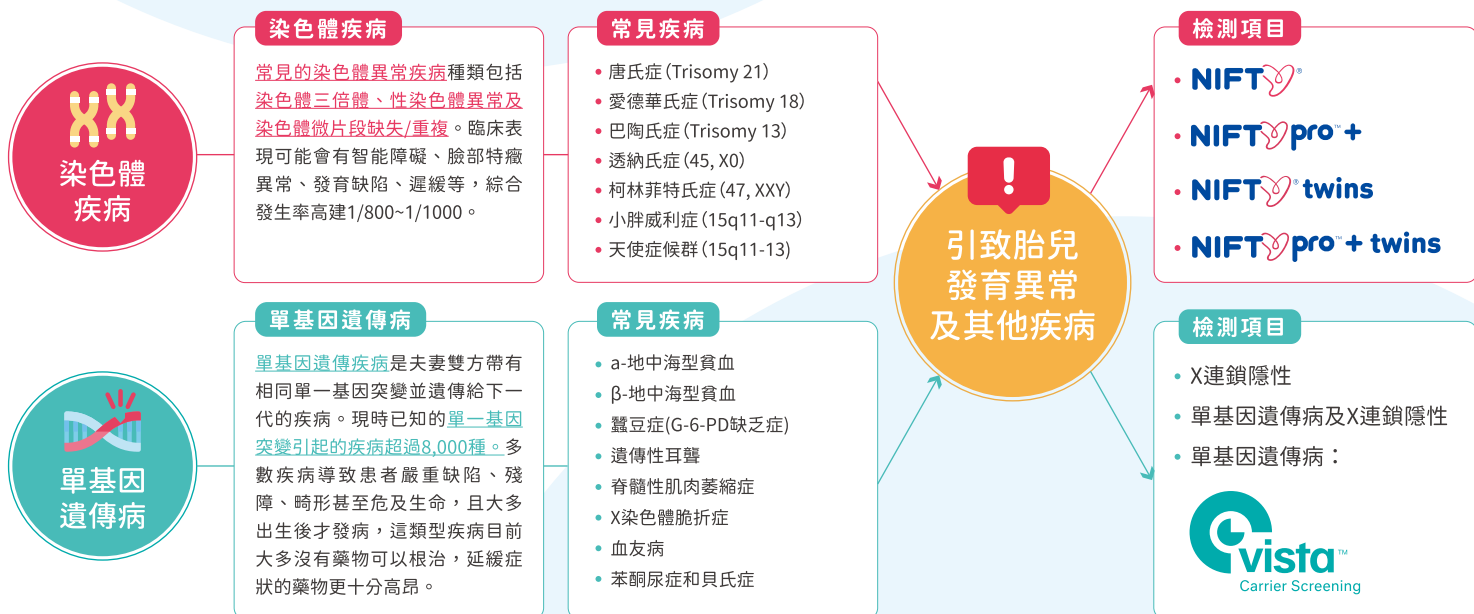
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1 NIFTy Pro+ 無創性胎兒染色體異常產前檢測

全面檢測23對染色體

三倍體綜合症	性染色體非整倍體
✓ T21唐氏綜合症	✓ 透納氏綜合症
✓ T18愛德華氏綜合症	✓ 柯林菲特氏綜合症
✓ T13巴陶氏綜合症	✓ XXX 染色體綜合症
罕見常染色體非整倍體	其它
✓ 9號染色體三倍體 (T9)	✓ XYY 三體綜合症
✓ 16號染色體三倍體 (T16)	✓ 92 種染色體微缺失及微重複疾病
✓ 22號染色體三倍體 (T22)	✓ 額外發現
	✓ 胎兒性別

2 Vista™ 遺傳病基因檢測 – 標準版

疾病	基因	發病率	攜帶率 ^[1]
1 脆性 X 綜合症	FMR1	1/5000 男性	1/250
2 杜興氏肌肉萎縮症	DMD	1/3500 新生男嬰	未知
3 乙型血友病	F9	1/20000 男性	未知
4 遺傳性耳聾	GJB2, SLC26A4	1/700 – 1/1000 新生兒	1/29 GJB2、1/59 SLC26A4
5 脊髓性肌肉萎縮症	SMN1	1/6000 – 1/10000	1/62
6 苯丙酮尿症	PAH	1/11144	1/53
7 威爾遜氏病 (肝豆狀核變性)	ATP7B	1/30000	1/90
8 糖原累積病	GAA	1/50000 中國南方	1/100
9 半乳糖血症	GALT	1/40000	1/317
10 地中海貧血	HBA1, HBA2	1/10000 – 1/50000 中國南方	1/6–1/52 中國南方
11 地中海貧血	HBB	66/10000 新生兒	1/16–1/88 中國南方
12 囊性纖維化	CFTR	/	未知

[1] <http://www.who.int/>



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ABSTRACTS ►

Session 3

**Dr. Lik-hang LEUNG***Specialist in General Surgery*

Dr. Leung graduated from the medical school of the University of Hong Kong in 2004. He commenced specialized surgical training at Pamela Youde Nethersole Eastern Hospital (PYNEH) in 2005. By 2008, He achieved membership in both the Royal College of Surgeons of Edinburgh and the College of Surgeons of Hong Kong. Following the completion of advanced training, the Fellowship of the Royal College of Surgeons of Edinburgh was conferred in 2012, marking a transition into sub-specialized practice focused on gastrointestinal surgery, minimally invasive techniques, and advanced endoscopy.

Dr. Leung has been serving as a Consultant Surgeon at Gleneagles Hospital since July 2020. He maintains a broad and sophisticated surgical portfolio. Clinical competencies span a wide range of elective and emergency general surgeries, including thyroidectomy, varicose vein interventions, laparoscopic hernia repair, and emergency gastrectomies. A defining milestone in my technical repertoire was the completion of intensive training in Endoscopic Submucosal Dissection (ESD) in Kobe, Japan (2015). In 2016, He was appointed as a recognized trainer in Colorectal Sub-specialty training for the College of Surgeons of Hong Kong.

Acute Hemorrhoidal Complications: Evidence-Based Intervention and Update of Non-Excisional Therapy

Acute hemorrhoidal complications, such as acutely thrombosed external hemorrhoids and strangulated internal piles, are frequent and highly distressing emergencies in primary care. For family physicians and general practitioners, mastering a structured, step-up approach—spanning from immediate medical optimization to timely surgical triage—is essential to alleviate acute suffering and prevent long-term morbidity.

This lecture provides a comprehensive, evidence-based roadmap tailored for the primary care setting. The first line of defence against acute crises remains medical stabilization. We will evaluate the evidence from dietary fiber adjustments, toilet behavior modification, to targeted short-term topical analgesics, and oral phlebotonics—specifically micronized purified flavonoid fractions (MPFFs)—to rapidly down-regulate acute inflammation and manage bleeding.

When conservative measures fall short, the paradigm shifts to non-excisional interventions. We will explore the indications for immediate in-clinic incision or excision of thrombosed external hemorrhoids within the early symptomatic window. Furthermore, the session will deliver an essential update on advanced, low-morbidity, non-excisional modalities—including rubber band ligation (RBL), injection sclerotherapy, and Doppler-guided hemorrhoidal artery ligation (HAL)—highlighting how these sphincter-sparing techniques minimize postoperative pain and accelerate recovery compared to traditional excisional surgery.

Crucially, the lecture will define clear, practical criteria on "when to refer." Practitioners will learn to identify red flags that mandate urgent specialist intervention, such as irreducible strangulation, extensive tissue necrosis, uncontrollable haemorrhage, or signs of systemic infection. By integrating current societal guidelines with real-world clinical pearls, this session aims to equip primary care physicians with the confidence to optimize frontline medical therapy, expertly navigate the boundary between non-invasive and invasive options, and ensure safe, timely referrals.



ABSTRACTS ►

Lunch Symposium



Dr. Davis Yung CHAN

Specialist in Dermatology and Venereology

Honorary Consultant, Department of Medicine, NTE Cluster, Hospital Authority

Dr. Chan Yung, Davis is a Hong Kong dermatologist and venereologist with extensive experience in both clinical practice and academic work. He is a Registered Specialist in Dermatology and Venereology and a Fellow of the Hong Kong Academy of Medicine, with additional qualifications in internal medicine, dermatology, and family medicine from Hong Kong, Glasgow, Monash, and the Royal Colleges of Physicians (UK).

Dr. Chan is the Medical Director of Apex Dermatology Institute. His previous roles include dermatologist positions in private practice and medical officer posts in the Department of Health's Social Hygiene Service and Tuen Mun Hospital. He has authored books and numerous publications on psoriasis, atopic dermatitis, biologics, skin disease patterns, and dermatologic procedures. He is also active as a speaker and moderator at local and international conferences, and serves in editorial and professional society roles. His main interests include inflammatory skin diseases, dermatologic surgery, and cosmetic dermatology.

Topical JAKi in the Management of Skin Disease

Topical JAK inhibition represents a significant advance in the management of inflammatory skin disease by targeting central immune pathways involved in cutaneous inflammation and pigment loss. This lecture reviews the clinical efficacy and practical use of ruxolitinib cream in non-segmental vitiligo and atopic dermatitis, with emphasis on data most relevant to frontline clinicians. Evidence from pivotal and long-term studies will be discussed, including progressive repigmentation in vitiligo, rapid itch relief and lesion improvement in atopic dermatitis, and an overall favorable tolerability profile. The session will also address patient selection, treatment expectations, and the place of topical ruxolitinib in routine practice for general practitioners and non-dermatology specialists managing challenging dermatologic disease.

ABSTRACTS ►

Lunch Symposium



Dr. Martin Man-ho Chung

*Specialist in Dermatology and Venereology
Honorary Clinical Assistant Professor, Department of Medicine,
The University of Hong Kong*

Dr. Martin Chung graduated from the University of Hong Kong with a distinction and a gold medal. He is a specialist and trainer in Dermatology and Venereology and a member of the Specialty Board. In addition, he has completed specialty training in Rheumatology. He currently serves as an Honorary Clinical Assistant Professor at the University of Hong Kong. He is also the Honorary Secretary of the Hong Kong College of Dermatologists, a council member of the Hong Kong Society of Paediatric Dermatology, and a regional coordinator for the Global Psoriasis Atlas.

Dr. Chung is actively involved in atopic dermatitis and psoriasis research as principal investigator and co investigator in multiple clinical trials.

Targeting the IL-4/IL-13 Pathway in Dermatology: A Multidisciplinary Approach

The IL-4/IL-13 cytokine axis represents a central regulatory mechanism in Type 2 inflammatory responses, driving the pathogenesis of multiple dermatological conditions including atopic dermatitis, chronic spontaneous urticaria, and eosinophilic dermatoses. Both cytokines signal through the shared IL-4 receptor alpha (IL-4R α) subunit, activating downstream JAK-STAT pathways that promote Th2 cell differentiation, IgE class switching, and barrier dysfunction.

This lecture examines the therapeutic potential of IL-4/IL-13 pathway modulation in dermatology through an integrated multidisciplinary lens, synthesizing insights from immunology, molecular biology, clinical dermatology, and translational medicine.

This comprehensive lecture will explore the molecular mechanisms underlying IL-4R α signaling cascades, STAT6 activation, and downstream effector functions in skin homeostasis and disease, followed by an examination of disease pathophysiology focusing on the role of IL-4/IL-13 in epidermal barrier disruption, filaggrin downregulation, and inflammatory cell recruitment. The presentation will analyze current therapeutic strategies including monoclonal antibody targeting with dupilumab, small molecule inhibitors, and emerging precision medicine approaches, while reviewing clinical evidence encompassing efficacy and safety data across dermatological indications, biomarker identification, and patient stratification strategies. Finally, we will discuss future directions in the field, including combination therapies, novel delivery systems, and personalized treatment algorithms that promise to revolutionize dermatological care through targeted IL-4/IL-13 pathway modulation.

Understanding IL-4/IL-13 pathway biology enables rational therapeutic design and optimization of patient outcomes across diverse dermatological conditions. This multidisciplinary approach facilitates translation of mechanistic insights into clinical practice, advancing precision dermatology care.

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References: 1. Augustin M, et al. EMJ Dermatol 2021;9[Suppl 1]:2-11. 2. Warren RB, et al. J Eur Acad Dermatol Venereol 2021;35:919-927. 3. Nast A, et al. J Eur Acad Dermatol Venereol 2020;34:2461-2498. 4. Enos CW, et al. J Am Acad Dermatol 2022;86:68-76. 5. Tildrakizumab summary of product characteristics. Sun Pharmaceutical Industries Limited. 6. Guselkumab prescribing information. Horsham, PA: Janssen Biotech, Inc.; 2024. 7. Ixekizumab prescribing information. Indianapolis, IN: Eli Lilly and Company; 2024. 8. Adalimumab prescribing information. North Chicago, IL: AbbVie Inc.; 2018. 9. Secukinumab prescribing information. New Jersey, NJ: Novartis Pharmaceuticals Corporation; 2023.

For Healthcare Professionals Only.
Full prescribing information available upon request.





ABSTRACTS ▶



Dr. Daniel Wai-sing CHU

*F.H.K.A.M. (Family Medicine), F.R.A.C.G.P., F.H.K.F.P., M.B.,B.S. (N.S.W.),
Dip. Occupational Medicine (C.U.H.K.)
Specialist in Family Medicine
Vice-President, Hong Kong Chinese Medical Association*

Dr. Daniel Chu served in the Hospital Authority for 20 years. He set up the Family Medicine services and training in HA as the Chief of Service and Consultant. Apart from leading the development of Family Medicine and Training, his work in HA included coordination and supervision the training of Family Physicians; overseeing the operation and planning the development of Staff Clinics, Family Medicine Specialist Clinics and General Out-patient Clinics in the HKEC.

From January, 2019 Dr. Chu started his practice in Central. He continues appear in radio weekly to share health information and answering audiences' question on air. During the 3 years COVID-19 pandemic he appears in different network channels to share information about the pandemic and continue his mission of "Family Doctor of Hong Kong people on air".

Adult Pneumococcal Disease Prevention in Hong Kong and the Next Generation Pneumococcal Conjugate Vaccine

Pneumococcal disease remains a substantial global health burden, particularly among adults aged 65 years and older and those with chronic medical conditions. Vaccination is the most effective and accessible preventive strategy; however, vaccine uptake remains suboptimal, and serotype replacement has diminished the impact of older pneumococcal vaccines. Newer pneumococcal conjugate vaccines offer broader serotype coverage and simplified single-dose administration, representing an important advancement in adult pneumococcal prevention.

The recently approved 21-valent pneumococcal conjugate vaccine, PCV21, may be particularly well aligned with the Hong Kong setting, as it includes serotypes that are prevalent among local adult populations and are not covered by other currently available vaccines. In addition, PCV21 has demonstrated robust immunogenicity against serotype 3, a clinically important serotype predominant in Hong Kong, and associated with invasive disease outcomes. Clinical data show that PCV21 induces strong serotype-specific antibody responses with an acceptable safety profile comparable to other pneumococcal conjugate vaccines. Modeling studies suggest that PCV21 may help reduce pneumococcal disease burden through its expanded serotype coverage.

This presentation will highlight the unmet need for improved pneumococcal prevention among high-risk adults in Hong Kong, and the potential role of PCV21 in addressing locally relevant serotypes and strengthening adult protection.

CAPVAXIVE (PCV21): A New Generation Pneumococcal Vaccine Aligned to Evolving Serotypes, Focused on IPD Prevention¹⁻³



● **100% coverage of the top 3 serotypes (3, 15A and 23A) causing IPD in adults aged ≥65 years in 2025 in Hong Kong^{2,3,*}**

● **22 *Streptococcus pneumoniae* serotypes are covered by PCV21 for the prevention of invasive disease in adults²**

● According to a phase 3 trial in adults (n=717), PCV21 demonstrated **comparable immunogenicity against ST3** compared with PCV15⁴

● **Established safety profile:** Most adverse events were mild-to-moderate injection-site pain, and fatigue, typically resolving within 3 days. The proportion of participants with solicited injection-site and systemic AEs were generally similar between vaccine groups within each cohort. Serious adverse events were experienced by 1.8% of all participants, including 1.2% of those who received PCV21, 3.4% of those who received PCV15, and 3.5% of those who received PPSV23. No deaths occurred during the study⁴

*Coverage percentage refers to the proportion of observed IPD serotypes included in the vaccine formulation and does not account for immunogenicity or effectiveness.

Study design (Scott P et al. 2024): This was a phase 3, double-blind (cohorts 1 and 2), open-label (cohort 3), multicenter, active-comparator, parallel assignment study. A total of 717 adults (vaccine-experienced adults ≥50 years of age) were enrolled to receive 2 single doses of pneumococcal vaccine as follows: cohort 1 (n=333) previously received PPSV23 and were randomized 2:1 to receive PCV21 or PCV15, respectively; cohort 2 (n=261) previously received PCV13 and were randomized 2:1 to receive PCV21 or PPSV23, respectively; cohort 3 (n=123) previously received PPSV23 + PCV13, PCV13 + PPSV23, PCV15 + PPSV23, or PCV15 and all received open-label PCV21. Immunogenicity was evaluated 30 days postvaccination using opsonophagocytic activity geometric mean titers and immunoglobulin G geometric mean concentrations for all PCV21 serotypes. The primary immunogenicity objective was to evaluate the serotype-specific opsonophagocytic activity (OPA) geometric mean titers (GMTs) at 30 days postvaccination for all V116 serotypes. Secondary objectives were to evaluate the serotype-specific IgG geometric mean concentrations (GMCs), as well as the geometric mean fold rise (GMFR) and proportion of participants with a ≥4-fold rise in serotype-specific antibodies from baseline (day 1) to 30 days postvaccination for all V116 serotypes. Safety was evaluated as the proportion of participants with adverse events.

Abbreviations: AE=adverse event; CHP=Centre for Health Protection; CI=confidence interval; GMC=geometric mean concentration; GMT=geometric mean titer; IPD=invasive pneumococcal disease; OPA=opsonophagocytic activity; PCV15=15-valent pneumococcal conjugate vaccine; PCV21=21-valent pneumococcal conjugate vaccine; ST3=serotype 3.

References: 1. The Government of the Hong Kong Special Administrative Region, Department of Health, Drug Office. CAPVAXIVE 21. Available from: https://www.drugoffice.gov.hk/eps/drug/productDetail/en/pharmaceutical_trade/160367. Accessed on 8 Jun 2026. 2. CAPVAXIVE, Hong Kong Product Circular. MSD, 3. Centre for Health Protection. Report on IPD. Available from: <https://www.chp.gov.hk/en/resources/29/639/1.html>. Accessed on 8 Jun 2026. 4. Scott P, et al. A Phase 3 Clinical Study to Evaluate the Safety, Tolerability, and Immunogenicity of V116 in Pneumococcal Vaccine-Experienced Adults 50 Years of Age or Older (STRIDE-4). Clin Infect Dis. 2024 Dec 17;73(13):1376-1374.

CAPVAXIVE Selected Safety Information

Indications: CAPVAXIVE is indicated for active immunisation for the prevention of invasive disease and pneumonia caused by *Streptococcus pneumoniae* in individuals 18 years of age and older. • The use of CAPVAXIVE should be in accordance with official recommendations. **Dosing:** Vaccination with CAPVAXIVE is recommended for selected individuals as follows: Individuals 18 years of age and older • 1 dose (0.5 mL). • The need for revaccination with a subsequent dose of CAPVAXIVE has not been established. **Paediatric population:** The safety and efficacy of CAPVAXIVE in children younger than 18 years of age have not been established. No data are available. **Contraindications:** Hypersensitivity to the active substances including diphtheria toxin, or to any of the excipients. **Precautions:** • In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. • As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic event following the administration of the vaccine. • Vaccination should be postponed in individuals suffering from acute severe febrile illness or acute infection. The presence of a minor infection and/or low-grade fever should not delay vaccination. • As with other intramuscular injections, the vaccine should be given with caution in individuals receiving anticoagulant therapy or those with thrombocytopenia or any coagulation disorder (such as haemophilia) because bleeding or bruising may occur following an intramuscular administration in these individuals. • Anxiety-related reactions, including vasovagal reactions (syncope), hyperventilation or stress-related reactions may occur in association with vaccination as a response to the needle injection. Stress-related reactions are temporary and resolve on their own. It is important that precautions are in place to avoid injury from fainting. • Safety and immunogenicity data on CAPVAXIVE are not available for individuals in immunocompromised groups. Vaccination should be considered on an individual basis. Based on experience with pneumococcal vaccines, immunocompromised individuals, including those receiving immunosuppressive therapy, may have a reduced immune response to CAPVAXIVE. • As with any vaccine, vaccination with CAPVAXIVE may not protect all vaccine recipients. This vaccine will only protect against *Streptococcus pneumoniae* serotypes included in the vaccine and to the cross-reactive serotype 15B. • This medicinal product contains less than 1 mmol sodium (23 mg) per dose, that is to say, essentially "sodium-free". • This medicinal product contains 0.5 mg of polysorbate 20 in each dose. Polysorbates may cause allergic reactions. **Adverse events:** The most frequently reported adverse reactions following vaccination with CAPVAXIVE in individuals 18 years of age and older were solicited. Overall, the most frequently reported adverse reactions were injection-site pain, fatigue, headache, and myalgia. The majority of local and systemic adverse reactions for individuals who received CAPVAXIVE were mild or moderate (based on intensity or size) and of short duration (≤ 3 days); severe reactions (defined as an event that prevents normal daily activity or size > 10 cm) occurred in ≤ 1.0% of adults. • For detailed side effects, please consult the full prescribing information. **Drug interactions:** Different injectable vaccines should always be administered at different injection sites. • CAPVAXIVE can be administered concomitantly with quadrivalent influenza vaccine (split virion, inactivated). There are no data on the concomitant administration of CAPVAXIVE with vaccines other than influenza vaccines. **Pregnancy:** There are no data on the use of CAPVAXIVE in pregnant women. • Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryofetal development, parturition or post-natal development. • Administration of CAPVAXIVE in pregnancy should only be considered when the potential benefits outweigh any potential risks for the mother and the foetus. **Breast-feeding:** • It is unknown whether CAPVAXIVE is excreted in human milk. **Fertility:** • No human data on the effect of CAPVAXIVE on fertility are available. Animal studies in female rats do not indicate harmful effects. Before prescribing, please consult the full prescribing information.

Consider PCV15 to help prevent IPD in view of rising ST3 IPD disease burden in Hong Kong^{1*}

Adults ≥50 years old

According to a phase 3, randomized, double-blind study (n=1202)



PCV15 was non-inferior to PCV13 for all 13 shared serotypes, superior for unique serotypes, and demonstrated superior immunogenicity against ST3²

60% higher immunogenicity against ST3 vs PCV13²
 GMT ratio (PCV15/PCV13): 1.60 (95% CI 1.38-1.85) at day 30

The most frequently reported AEs (>5% of participants in either group) were the solicited events of injection-site pain, injection-site erythema, injection-site swelling, arthralgia, fatigue, headache, and myalgia. Most of the AEs were assessed as mild²

Infants

According to a phase 3, randomized, double-blind study (n=1720)



PCV15 was non-inferior to PCV13 for all 15 shared serotypes based on IgG response rates at PD 3 and demonstrated superior immunogenicity against ST3³

73% higher immunogenicity against ST3 vs PCV13^{3,4}
 GMC ratio (PCV15/PCV13): 1.73 (95% CI 1.61-1.87) P<0.001

>92% of participants experienced at least one AE. The most common AEs were those solicited in the trial, with the 3 most frequently reported AEs being irritability, somnolence, and injection-site pain³

ST3: 41% of total IPD cases in Hong Kong in 2025^{1†}



ST3 has a thick polysaccharide capsule, making it highly virulent⁵

ST3: ~40% of AMR serotypes based on epidemiological analyses of medical records in IPD adult (n=425) and pediatric patients (n=37661)^{6†}. (AMR narrows treatment options, making treatment more challenging!⁸)

¹According to data from DHP
 Study design (Platt HL, et al. 2022): This was a phase 3, randomized, double-blind, active comparator-controlled study in which pneumococcal vaccine-naïve adults ≥50 years of age or older were randomized to receive either VAXNEUVANCE (N=604) or PCV13 (N=601). The study was conducted from June 2019 through March 2020, enrolling 1,202 participants. The primary immunogenicity objectives were to compare VAXNEUVANCE to PCV13 for noninferiority of immune responses at 30 days postvaccination for shared serotypes (noninferiority met when lower bound of the 2-sided 95% CI of the OPA GMT ratio >0.5) and superiority of immune response at 30 days postvaccination for unique serotypes (superiority met when lower bound of the 2-sided 95% CI of the difference between the proportions of participants with a ≥4-fold rise >0.1). The secondary immunogenicity objective was to assess superiority of immune response for serotype 3 at 30 days postvaccination (superiority met when lower bound of the 2-sided 95% CI of the difference between the proportions of participants with a ≥4-fold rise >0.1).
 Study design (Lupinacci R, et al. 2023): This was a phase 3, randomized, active comparator-controlled, double-blind study to evaluate the safety, tolerability, and immunogenicity of a 4-dose regimen of Vaxneuvance in healthy infants (protocol V114-029). It was conducted from June 2019 to May 2021. The study enrolled 1720 participants, randomized in a 1:1 ratio to receive a 4-dose vaccination regimen of Vaxneuvance (n=858) or PCV13 (n=862). Primary immunogenicity objectives were to compare Vaxneuvance to PCV13 for non-inferiority for all serotypes using anti-Phs serotype-specific IgG response rates (proportion of participants meeting the serotype-specific IgG threshold value of 0.35 μg/ml) at 30 days PD3 and IgG geometric mean concentrations (GMCs) at 30 days PD3 and 30 days PD4. Serotypes 22F and 33F were compared to the lowest response rate or IgG GMC for any of the 15 shared serotypes among recipients of PCV13, excluding serotype 3. For IgG GMCs, the lower bound of the 2-sided 95% CI for the Vaxneuvance/PCV13 GMC ratios needed to be > 0.5 to meet non-inferiority criteria. Secondary objectives were to compare Vaxneuvance to PCV13 for superiority for IgG against serotypes 3, 22F, and 33F using anti-Phs serotype-specific IgG response rates at 30 days PD3 and IgG GMCs at 30 days PD3 and 30 days PD4. For IgG response rates and IgG GMCs to serotypes 22F and 33F, the lower bound of the 2-sided 95% CI for the between-group differences needed to be > 10 percentage points and > 2.0, respectively, to meet superiority criteria. For shared serotype 3, superiority based on IgG response rates and IgG GMCs was demonstrated if the lower bound of the 2-sided 95% CI for the between-group differences was > 10 percentage points and > 1.2, respectively.
 Study design (Lau JCH, et al. 2022): Data were retrieved from the population-wide CDARS for all adult IPD specific hospitalization episodes from 2012 – 2019. Hospitalized patients aged ≥18 years with IPD diagnosis defined by International Classification of Diseases, 9th Revision, Clinical Modification were included. 432 episodes were identified from 425 patients with IPD. Collected data include patient demographics, diagnoses, and microbiological culture and laboratory test results – including antimicrobial sensitivity and serotyping. Descriptive statistics were tabulated by each hospitalization episode for (1) antimicrobial susceptibility (Sensitive/Intermediate/Resistance), and (2) serotype of the isolate.
 Study design (Lau JCH, et al. 2023): Data were retrieved from the population-wide CDARS for hospitalization episodes with IPD, invasive infections, and OM from 2012-2019 for patients aged ≥18 years. Diagnoses were defined by International Classification of Diseases, 9th Revision, Clinical Modification. 4593 episodes were identified from 37661 patients. Collected data include patient demographics, diagnoses, and microbiological culture and laboratory test results – including antimicrobial sensitivity and serotyping. Descriptive statistics were tabulated by each hospitalization episode for (1) antimicrobial susceptibility (Sensitive/Intermediate/Resistance), and (2) serotype of the isolate.
 Abbreviations: AEs=adverse events; AMR=antimicrobial resistance; CDARS=clinical data analysis and reporting system; DHP=Centre for Health Protection; CI=confidence interval; GMC=geometric mean concentration; IgG=immunoglobulin G; IPD=invasive pneumococcal disease; IgG=geometric mean titer; OM=otitis media; OPA=optochinophagocytic assay; PCV13=13-valent pneumococcal conjugate vaccine; PCV15=15-valent pneumococcal conjugate vaccine; 10-post-dose; Phs=pneumococcal polysaccharide; ST3=serotype 3.
 References: 1. Centre for Health Protection, Communicable Disease Watch, Report on IPD 2. Platt HL, et al. A phase 3 trial of safety, tolerability, and immunogenicity of V114, a 15-valent pneumococcal conjugate vaccine, compared with 13-valent pneumococcal conjugate vaccine in adults 50 years of age and older (PNEU-AGE). Vaccine. 2022;40(11):162-172. 3. Lupinacci R, et al. A phase 3, multicenter, randomized, double-blind, active-comparator-controlled study to evaluate the safety, tolerability, and immunogenicity of a 4-dose regimen of V114, a 15-valent pneumococcal conjugate vaccine, in healthy infants (PNEU-PED). Vaccine. 2022;40(11):162-172. 4. VAXNEUVANCE Product Circular MSO. 5. Hammerschmidt S, et al. Illustration of Pneumococcal Polysaccharide Capsule during Adherence and Invasion of Epithelial Cells. Infect Immun. 2005;73(8):4453-4467. 6. Lau JCH, et al. ANTIMICROBIAL RESISTANCE IN ADULT PATIENTS WITH INVASIVE PNEUMOCOCCAL DISEASE IN HONG KONG – EPIDEMIOLOGICAL ANALYSIS OF MEDICAL RECORDS 2012-2019 (Poster #14693). Abstract Book of 7th World One Health Congress (2022). 7th World One Health Congress (micropress.com). Accessed on Nov 21, 2022. 7. Lau JCH, et al. PV0495 - Antimicrobial resistance in paediatric patients with pneumococcal infection in Hong Kong - epidemiology analysis of medical records 2012-2019 (ID 620) (Poster 0310) - E-poster viewing. A508.b Bacterial pneumonia (ID 167). ESPD 2023. 8. Subramanian R, et al. Persistence of Pneumococcal Serotype 3 in Adult Pneumococcal Disease in Hong Kong. Vaccines (Basel). 2021;9(7):756.

VAXNEUVANCE Selected Safety Information: Vaxneuvance is indicated for active immunisation for the prevention of invasive disease, pneumonia and acute otitis media caused by *Streptococcus pneumoniae* in infants, children and adolescents from 6 weeks to less than 18 years of age. Vaxneuvance is indicated for active immunisation for the prevention of invasive disease and pneumonia caused by *Streptococcus pneumoniae* in individuals 18 years of age and older. The use of Vaxneuvance should be in accordance with official recommendations. **Dosing:** Vaccination with Vaxneuvance is recommended for selected individuals as follows: Individuals 18 years of age and older: 1 dose (0.5 mL). The need for revaccination with a subsequent dose of Vaxneuvance has not been established. Paediatric population: The safety and efficacy of Vaxneuvance in children and adolescents less than 18 years of age please consult the full prescribing information. Special populations: One dose of Vaxneuvance may be given to individuals who have one or more underlying conditions predisposing them to an increased risk of pneumococcal disease (e.g., adults living with human immunodeficiency virus (HIV) or immunocompetent adults 18 to 49 years of age with risk factors for pneumococcal disease). **Contraindications:** Hypersensitivity to the active substances, to any of the excipients, or to any diphtheria toxin-containing vaccine. **Precautions:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Vaxneuvance must not be administered intravascularly. As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic event following the administration of the vaccine. Vaccination should be postponed in individuals suffering from acute severe febrile illness or acute infection. The presence of a minor infection and/or low-grade fever should not delay vaccination. As with other intramuscular injections, the vaccine should be given with caution to individuals receiving anticoagulant therapy, or to those with thrombocytopenia or any coagulation disorder such as haemophilia. Bleeding or bruising may occur following an intramuscular administration in these individuals. The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation series to very premature infants (born < 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in this group of infants, vaccination generally should not be withheld or delayed. Immunocompromised individuals, whether due to the use of immuno-suppressive therapy, a genetic defect, HIV infection, or other causes, may have reduced antibody response to active immunisation. Safety and immunogenicity data for Vaxneuvance are available for individuals living with HIV infection. **Drug interactions:** Different injectable vaccines should always be administered at different injection sites. Immunosuppressive therapies may reduce the immune responses to vaccines. Infants and children aged 6 weeks to less than 2 years: Vaxneuvance can be given concomitantly with any of the following vaccine antigens, either as monovalent or combination vaccines: diphtheria, tetanus, pertussis, poliovirus (serotypes 1, 2 and 3), hepatitis A, hepatitis B, Haemophilus influenzae type b, measles, mumps, rubella, varicella and rotavirus vaccine. Children and adolescents 2 to less than 18 years of age: There are no data on the concomitant administration of Vaxneuvance with other vaccines. Data from a post-marketing clinical study evaluating the impact of prophylactic use of antipyretics (ibuprofen and paracetamol) on the immune response to other pneumococcal vaccines suggest that administration of antipyretics concomitantly or within the same day of vaccination may reduce the immune response after the infant series. Responses to the booster dose administered at 12 months were unaffected. The clinical significance of this observation is unknown. Adults: Vaxneuvance can be administered concomitantly with seasonal quadrivalent influenza vaccine (split virus, inactivated). There are no data on the concomitant administration of Vaxneuvance with other vaccines. **Pregnancy:** There is limited experience with the use of Vaxneuvance in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryo/fetal development, parturition or post-natal development. Administration of Vaxneuvance in pregnancy should only be considered when the potential benefits outweigh any potential risks for the mother and the foetus. **Breast-feeding:** It is unknown whether Vaxneuvance is excreted in human milk. **Fertility:** No human data on the effect of Vaxneuvance on fertility are available. Animal studies in female rats do not indicate harmful effects.

Before prescribing, please consult the full prescribing information.

ABSTRACTS ►

Session 4



Dr. Mario Wai-kwong CHAK

*Consultant, Department in Paediatrics and Adolescent Medicine, Tuen Mun Hospital
Honorary Assistant Clinical Professor, The University of Hong Kong
Honorary Assistant Clinical Professor, The Chinese University of Hong Kong*

Dr. Chak is the Consultant at the Department of Paediatrics and Adolescent Medicine in Tuen Mun Hospital. He is also the Honorary Clinical Assistant Professor of The University of Hong Kong and the Clinical Associate Professor (Honorary) of The Chinese University of Hong Kong. Dr. Chak attained the Fellowship of Hong Kong Academy of Medicine (Paediatrics) and Hong Kong College of Paediatricians in 2002. Dr. Chak has been accredited to be the first fellow of the Subspecialty of Paediatric Neurology and Developmental Behavioural Paediatrician in 2013. Dr. Chak is currently the trainer in Paediatrics and Paediatric Neurology. Dr. Chak has a special interest in Paediatric Epilepsy. He has received overseas training in EEG, Epilepsy and Presurgical Evaluation for Epilepsy Surgery in British Columbia Children's Hospital in Vancouver, Royal Children's Hospital in Melbourne and Department of Epileptology, The University Clinic in Bonn, Fondation Ophtalmologique Adolphe de Rothschild in Paris, respectively. Dr. Chak has passed the ASEPA (Asian Epilepsy Academy)- ASNA (Asean Neurological Association) EEG Examination Board in 2009 and is hereby certified as qualified Electroencephalographer. Dr. Chak is also the team leader of Tuen Mun Hospital Paediatrics and Adolescent Epilepsy Surgery Team which has just attained the outstanding team award in NTWC in 2016. Dr. Chak is currently appointed to be the Chairman of Neurophysiology Subcommittee of Electro-Medical Diagnostic Unit of New Territories West Cluster.

Central Nervous System Dysmyelinating Disorders in Children

Various types of central nervous system (CNS) dysmyelinating disorders can present during childhood and adolescence. Successful clinical management relies on accurate and early diagnosis. In this upcoming talk, the speaker will share his clinical experience in diagnosing and differentiating various types of dysmyelinating disorders—including Multiple Sclerosis, Neuromyelitis Optica Spectrum Disorders, and Anti-MOG Dysmyelinating Disease—by recognizing their specific clinical features, radiological imaging findings, and laboratory test results. Furthermore, referencing updated international guidelines, he will discuss how to manage these dysmyelinating disorders using various immunotherapies to optimize patients' clinical and neurological outcomes.



ABSTRACTS ▶



Dr. Johnny Yau-cheung CHANG

Specialist in Endocrinology, Diabetes & Metabolism

Dr. Chang obtained his MBBS from the University of Hong Kong in 2015 and was admitted as a Member of the Royal Colleges of Physicians of the United Kingdom in 2018. He completed specialist training in endocrinology, diabetes and metabolism in 2022, and was subsequently elected Fellow of the Hong Kong College of Physicians and the Hong Kong Academy of Medicine. He further attained subspecialty accreditation in advanced internal medicine in 2023.

He currently serves as Associate Consultant at Yan Chai Hospital and Honorary Clinical Tutor in the Department of Medicine, School of Clinical Medicine, LKS Faculty of Medicine, the University of Hong Kong.

Dr. Chang has published in multiple peer-reviewed journals and presented his research at local and international scientific meetings. He contributes to the field through invited lectures and publications on obesity management and endocrine disorders.

He serves as President-Elect of the Hong Kong Obesity Society (HKOS), an organisation committed to raising public awareness of obesity and fostering collaboration among local and international healthcare professionals in the field of obesity and related metabolic diseases.

The Biology of Obesity: Anti-Obesity Medications and the Challenge of Weight Regain

Obesity is associated with a wide spectrum of metabolic, mechanical, psychological, functional, and social comorbidities, making effective long-term management central to improving health outcomes. Yet sustained weight loss remains difficult: powerful physiological adaptations drive weight regain once treatment stops, underscoring the need to approach obesity as a chronic disease requiring structured, ongoing care.

This presentation reviews the pathophysiology of obesity and the mechanisms underlying weight regain, before examining the current landscape of anti-obesity medications (AOMs). Particular focus is given to incretin-based therapies — GLP-1 receptor agonists and GLP-1/GIP dual agonists — with a summary of evidence supporting their efficacy in weight reduction and in managing obesity-related comorbidities. The presentation further explores patient selection, the clinical implications of medication discontinuation, and the integration of lifestyle interventions within a comprehensive, long-term management framework.

ABSTRACTS ►

Session 5



Dr. Roland Ching-yu LEUNG

Consultant, Medical Oncology, Department of Medicine, Queen Mary Hospital

I am a medical oncologist trained in the US at New York University Medical Center and Memorial Sloan Kettering Cancer Center. My main interest is the exploration of predictive bio-markers in the clinical treatment of cancer. With the explosion of molecular targeted therapies with specific target of action, it is imperative that we as oncologists have access to technology which can predict which patients will benefit most from these treatment and not expose patients to empirical treatment. Since returning to Hong Kong 16 years ago, I focus on breast cancer, adenocarcinoma of lung, neuroendocrine tumours and tumours with targetable genetic aberrations like melanoma, some GI cancers, GISTs and a subset of sarcomas. Currently I am a consultant in the Department of Medicine, Queen Mary Hospital and honorary associate professor in Department of Medicine, University of Hong Kong.

Transformative Survival in Lung Cancer, the Power of Personalized Medicine, Targeted Drug Discovery and Immunotherapy

Lung cancer is the number one cancer burden in Hong Kong in terms of mortality. In the past two decade, there has been tremendous breakthrough in the systemic treatment for this disease. The advances made in the field of molecular biology, immuno oncology and translational research were instrumental in bringing these breakthrough.



ABSTRACTS ▶



Ms. Erica Bing-bing LAM

Principal Assistant Secretary for the Health Bureau

Ms. LAM joined the Administrative Officer grade of the HKSAR Government in 2013. She currently serves as Principal Assistant Secretary of the Health Bureau, responsible for policies related to information technology and data applications in healthcare services, including the promotion of smart healthcare and the development of “eHealth+”. She has served in the Development Bureau, the Central and Western District Office, the former Transport and Housing Bureau, and the Hong Kong Economic and Trade Office in New York, handling matters such as land planning, district administration, logistics, maritime affairs, trade and economic relations, and international liaison.

She holds a Bachelor of Business Administration (Law) from The University of Hong Kong and a Master of Public Administration from Columbia University.

Development of eHealth+

eHealth is a territory-wide electronic health platform launched by the Government in 2016. It enables citizens to authorise public and private healthcare providers to access and share their electronic health records for healthcare purposes.

Building on the strengths of eHealth, the Government announced in the 2023 Policy Address the initiative to roll out the eHealth+ five-year development plan to transform eHealth into a comprehensive healthcare information infrastructure that integrates multiple functions of data sharing, service delivery and care journey management. The Government is taking forward the eHealth+ five-year development plan in accordance with the patient-centric principle and four strategic directions, namely, One Health Record, One Care Journey, One Digital Front Door to Empowering Tool, and One Health Data Repository. Based on these strategic directions, the Government have formulated a series of enhancement measures, including launching nine core functions covering each key stage and touchpoint of the care process.

This lecture will provide background on eHealth and offer an overview of the above developments, strategic directions, and core functions of eHealth+.



The reference treatment for venous diseases

Chronic venous disease

Hemorrhoidal disease



1. Nicolaides A, et al. Management of chronic venous disorders of the lower limbs. Guidelines according to scientific evidence. Part I. Int Angiol. 2018;37:181-254. 2. Mansilha A, et al. Pharmacological treatment for chronic venous disease: An umbrella review of systematic reviews. Int Angiol. 2022; 41(3):249-257. 3. Lohsiriwat V et al. Recurrence rates and pharmacological treatment for hemorrhoidal disease: a systematic review. Adv Ther. 2023;40:117-132.

COMPOSITION*: Daflon tab 500mg (Micronized, purified flavonoid fraction 500 mg; 450 mg diosmin; 50 mg flavonoids expressed as hesperidine.) Daflon tab 1000mg (Micronized, purified flavonoid fraction 1000 mg; 900 mg diosmin; 100 mg flavonoids expressed as hesperidine.) **INDICATIONS***: This medicine is a venotonic (it increases venous tone) and a vasculoprotector (it increases resistance in small blood vessels). It is recommended for treating venous circulation disorders (heavy legs, pain, restless legs) and functional signs related to hemorrhoidal attack. **DOSAGE AND ADMINISTRATION***: In venous disease: 1000mg daily. In acute hemorrhoidal attacks: the dosage can be increased up to 3000mg daily. **CONTRAINDICATIONS***: Hypersensitivity to the active substance or to any of the excipients. **WARNINGS***: The administration of this product for the symptomatic treatment of acute hemorrhoids does not preclude treatment for other anal conditions. If symptoms do not subside promptly, a proctological examination should be performed and the treatment should be reviewed. Excipients: 500mg and 1000mg tablet and 1000mg tablet orange aroma: sodium-free. 1000mg chewable tablet orange aroma: contains sorbitol and benzyl alcohol. 1000mg tablet orange aroma: contains benzyl alcohol. 1000mg oral suspension: patients with rare hereditary problems of fructose intolerance should not take this medicine. **INTERACTION(S)***: None. **FERTILITY***. **PREGNANCY/LACTATION***: Treatment should be avoided. **DRIVE & USE MACHINES***. **UNDESIRABLE EFFECTS***: Common: diarrhoea, dyspepsia, nausea, vomiting. Rare: dizziness, headache, malaise, rash, pruritus, urticaria. Uncommon: colitis. Frequency not known: abdominal pain, isolated face, lip, eyelid oedema. Exceptionally Quincke's oedema. **OVERDOSE***. **PROPERTIES***: Vascular protector and venotonic. daflon® acts on the return vascular system: it reduces venous distensibility and venous stasis; in the microcirculation, it normalizes capillary permeability and reinforces capillary resistance. **PRESENTATION***. **SERVIER HONG KONG LIMITED**, Flat 08-09, 43/F, Times Square Tower One, 1 Matheson Street, Causeway Bay, Hong Kong. www.servier.hk * For complete information, please refer to the Summary of Product Characteristics.

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DO MORE WITH LESS^{1,2}

Acute HD attack

Day 1-4

3



Day 5-7

2



Protection from HD relapse

At least
2 months

1



Post HD procedures

Day 1-10



Day 11-30



CVD

3 months



1. Local SmPC of Daflon 1000mg. 2. Godeberge P., et al. J Comp Eff Res 2021;10(10):801-813. 3. Adv Ther. 2020 Feb;37(Suppl 1):1-5. doi: 10.1007/s12325-019-01218-8. Epub 2020 Jan 22.

COMPOSITION*: Daflon tab 500mg (Micronized, purified flavonoid fraction 500 mg; 450 mg diosmin; 50 mg flavonoids expressed as hesperidine.) Daflon tab 1000mg (Micronized, purified flavonoid fraction 1000 mg; 900 mg diosmin; 100 mg flavonoids expressed as hesperidine.) **INDICATIONS***: This medicine is a venotonic (it increases venous tone) and a vasculoprotector (it increases resistance in small blood vessels). It is recommended for treating venous circulation disorders (heavy legs, pain, restless legs) and functional signs related to haemorrhoidal attack. **DOSAGE AND ADMINISTRATION***: In venous disease: 1000mg daily. In acute hemorrhoidal attacks: the dosage can be increased up to 3000mg daily. **CONTRAINDICATIONS***: Hypersensitivity to the active substance or to any of the excipients. **WARNINGS***: The administration of this product for the symptomatic treatment of acute hemorrhoids does not preclude treatment for other anal conditions. If symptoms do not subside promptly, a proctological examination should be performed and the treatment should be reviewed. Excipients: 500mg and 1000mg tablet and 1000mg tablet orange aroma: sodium-free. 1000mg chewable tablet orange aroma: contains sorbitol and benzyl alcohol. 1000mg tablet orange aroma: contains benzyl alcohol. 1000mg oral suspension: patients with rare hereditary problems of fructose intolerance should not take this medicine. **INTERACTIONS***: None. **FERTILITY***: **PREGNANCY/LACTATION***: treatment should be avoided. **DRIVE & USE MACHINES***: **UNDESIRABLE EFFECTS***: Common: diarrhoea, dyspepsia, nausea, vomiting. Rare: dizziness, headache, malaise, rash, pruritus, urticaria. Uncommon: colitis. Frequency not known: abdominal pain, isolated face, lip, eyelid oedema. Exceptionally Quincke's oedema. **OVERDOSE***: **PROPERTIES***: Vascular protector and venotonic. daflon® acts on the return vascular system: it reduces venous distensibility and venous stasis; in the microcirculation, it normalizes capillary permeability and reinforces capillary resistance. **PRESENTATION***: **SERVIER HONG KONG LIMITED**, Flat 08-09, 43/F, Times Square Tower One, 1 Matheson Street, Causeway Bay, Hong Kong. www.servier.hk * For complete information, please refer to the Summary of Product Characteristics.

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

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

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

[†] DUPIXENT® 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. DUPIXENT® 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. DUPIXENT 200 mg Hong Kong Prescribing Information. 5. DUPIXENT 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

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. * 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. *PN:* 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. *EoE:* 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. 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. **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.** APHIX-DUP-23.10

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DUPIXENT®
(dupilumab) injection
200mg • 300mg

One Target, Dual Action, Six Indications

DUPIXENT targets IL-4Ra with dual action on both IL-4 & IL-13 to reduce Type 2 inflammation^{1,2}

DUPIXENT - your versatile biologic that targets six conditions³



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[‡]



Chronic Obstructive Pulmonary Disease (COPD)

- As add-on maintenance treatment with other medicines for adults with uncontrolled COPD[§]

Newly approved

† 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.

¶ Characterised by raised blood eosinophils, on a combination of an inhaled corticosteroid (ICS), a long acting beta₂-agonist (LABA), and a long-acting muscarinic antagonist (LAMA), or on a combination of a LABA and a LAMA if ICS is not appropriate.

Abbreviations: AD=atopic dermatitis; COPD = chronic obstructive pulmonary disease; CRSwNP= chronic rhinosinusitis with nasal polyposis; EoE=eosinophilic esophagitis; FeNO=fractional exhaled nitric oxide; ICS=inhaled corticosteroids; LABA = long acting beta₂-agonist; LAMA = long acting muscarinic antagonist; 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. Chronic obstructive pulmonary disease (COPD) In adults as add-on maintenance treatment for uncontrolled COPD characterised by raised blood eosinophils on a combination of ICS, LABA, and LAMA, or on a combination of LABA and LAMA if ICS is not appropriate. **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 <40 kg: initial dose of 400 mg (two 200 mg injections), followed by 200 mg Q2W. Body weight ≥40 kg: same dosage as adults. AD children (6-11y/o): Body weight 15kg-≤40 kg: initial dose of 300 mg on Day 1 followed by 300 mg on Day 15, then 300mg Q4W. Body weight ≥40 kg: same dosage as adults. * The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg-≤40 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-≤40 kg: 300 mg Q4W. Body weight 30kg-≤40 kg: 200 mg Q2W, or 300 mg Q4W. 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: 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. COPD: 300 mg Q2W. Consider discontinuing treatment in patients who have shown no response after 52 weeks. 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 symptoms, acute exacerbations of asthma or COPD, 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 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 injection. 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.**

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CHAIRPERSONS ►



Prof. Bernard Man-yung CHEUNG

*PhD (Cantab), FRCP, FRCPE, FHKCP, FHKAM(Medicine), FBPhS, FBHS
President, The Federation of Medical Societies of Hong Kong*

Bernard Cheung is the Chief Executive Officer of the Greater Bay Area International Clinical Trials Institute based in the Hetao Shenzhen-Hong Kong Science and Technology Innovation Cooperation Zone. Professor Cheung was educated at Sevenoaks School and studied Medicine at Cambridge. Previously, he was Professor of Clinical Pharmacology and Therapeutics at the University of Birmingham, and the Sun Chieh Yeh Heart Foundation Professor in Cardiovascular Therapeutics at the University of Hong Kong. He was a Consultant Physician of Queen Mary Hospital and the Director of the Phase 1 Clinical Trials Units in Queen Mary Hospital and the University of Hong Kong-Shenzhen Hospital. Prior to the present appointment, he was the Biotechnology Director in the Innovation and Technology Commission. He is also the President of the Federation of Medical Societies of Hong Kong and the Editor-in-Chief of Postgraduate Medical Journal. Prof Cheung's research interest is in cardiovascular diseases and the metabolic syndrome.



Dr. Chun-kong NG

*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 currently serve as 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 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. His is also Panel Chairman of the HAHO Central Institutional Review Board.

Dr Ng serve as Chairman of the Specialty Board in Respiratory Medicine and member of the Education and Accreditation Committee (E&AC) of the Hong Kong College of Physicians. His is First Vice President of the Federation of Medical Societies of Hong Kong (FMSHK), Board Member of the Hong Kong Lung Foundation (HKLF), Executive Member of the CHEST Delegation Hong kong and Macau and Board Member of the Hong Kong Chinese Medical Association (HKCMA). He was appointed as Council Member of the Hong Kong Council on Smoking and Health (COSH).



CHAIRPERSONS ►



Dr. Samuel KS FUNG

*Consultant Nephrology & Physician of the Department of Medicine and Geriatrics, Hong Kong Jockey Club Nephrology & Urology Centre, Princess of Margaret Hospital, Hong Kong
Hon Associate Professor of Chinese University of Hong Kong
Past Chairman of the Hong Kong Society of Nephrology*

Dr Fung graduated from the Medical School, University of Hong Kong and received post graduate training in Nephrology & Transplantation in Hong Kong, University of Oxford, John Radcliffe Hospital, Oxford Transplantation Centre and University of London, Guy's & St. Thomas's Hospitals, London, United Kingdom.

Dr Fung was Chief of Nephrology, and now served as Consultant Nephrology & Physician of the Department of Medicine and Geriatrics, Hong Kong Jockey Club Nephrology & Urology Centre, Princess of Margaret Hospital, Hong Kong. He had served in the Central Renal Committee (CRC) and the Central Transplant Committee of the Hospital Authority. He served as the CRC transplant lead and helped in the committee formulating the pair exchange living renal transplant program in Hong Kong. He served Hospital Management Committee Member of Princess Margaret Hospital and was chairman of the Kowloon West Cluster Transplant Coordinating Committee and Kowloon West Cluster Community Engagement & Volunteer Service Coordinating Committee.

He served in Hong Kong Society of Nephrology (HKSNG) as Chairman of the Society from 2012-2014. During the tenure, HKSNG co-hosted with the International Society of Nephrology the ISN World Congress of Nephrology 2013 in Hong Kong. He was the Vice President of the Congress and Scientific Committee Member 1st International Congress of Chinese Nephrologists & Scientific Congress on Nephropathies held at the HK Convention Centre, Hong Kong 11-13th December 2015. He was the Co-Chairman for the Hong Kong Hospital Authority Central Renal Committee Hospital Authority Commission Training Workshop & Symposium on Vascular Access: A Vital Key to Success in Haemodialysis on 15-16 January 2011. He also served in the Organizing Committee Member for the World Kidney Day Hong Kong.

For medical education, Dr Fung teaches medical students with appointment as Hon Associate Professor of Chinese University of Hong Kong and served as Clinical Examiner at the Chinese University of Hong Kong for Medical Students Final Examination, examiner for Licensing Examination of the Medical Council of Hong Kong. He had served on the Hong Kong College of Physician Nephrology Training Board and the Specialty Programme Director in Kowloon Region.

He has publications in peer-reviewed journals in research on renal anemia, BK nephropathy, hyperparathyroid renal bone disease and Nocturnal Home Haemodialysis. Currently, he has been working as site Principal Investigator for the studies ASCEND study on renal anemia, TESTING study, PROTECT on IgA Nephropathy, DUPLEX Study on FSGS, VALOR on delaying CKD progression, VISTERRA on IgA Nephropathy & ADPKD, ALIGN, iCAN Trials, CSL300_2301 POSIBIL6ESKD study.

CHAIRPERSONS ►



Dr. Jane Chun-kwong CHAN

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

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



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*

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. She is the lead trainer for ICN Leadership for Change Programme™ in Hong Kong since 2010. 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 organizations for service development and training.



CHAIRPERSONS ►



Dr. Kingsley Hau-ngai CHAN

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

Dr. Kingsley Chan is a dermatologist in private practice in Hong Kong. He received his medical training at the University of Hong Kong. He completed his basic physician training at the Queen Mary Hospital and his specialist training at the Department of Health. Dr. Chan's practice encompasses both medical and cosmetic dermatology. He is also an active member of the Hong Kong medical professional and serves as a Council Member 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.



Dr. Alson Wai-ming CHAN

*First Fellow, Subspecialty of Paediatric Immunology, Allergy & Infectious Diseases, HKCPaed
FHKAM(Paed), FHKCPaed, FRCPCH, DCH (Ireland), Dip Ger Med RCPS (Glasg),
PDipCmmunityGeriatrics(HK), MBChB
Specialist in Paediatric Immunology, Allergy and Infectious Diseases*

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. Siu-pui LAM

Specialist in Respiratory Medicine

Honorary Clinical Associate Professor, the Jockey Club School of Public Health and Primary Care, the Chinese University of Hong Kong

Dr. Lam is a respiratory specialist with additional accreditation in rehabilitation medicine.

He has received his training in Respiratory Medicine at Queen Mary Hospital HK and Dept. of Allergy & Immunology at the Imperial College UK. He has strong interest in Asthma & COPD management and has been the Director of Pulmonary rehabilitation services at Wong Tai Sin Hospital for more than 20 years. Currently, Dr. Lam is the Consultant in Respiratory Medicine in Pedder Health Group.

Dr Lam has been the President of Hong Kong Association of Rehabilitation Medicine since 2023 and executive committee member of the Federation Medical Societies of Hong Kong since 2025. In addition, he has also taken the position as the Honorary Clinical Associate Professor in the Jockey Club School of Public Health and Primary Care, Chinese University of Hong Kong since 2013.

Dr. Lam has presented topics on asthma, COPD and pulmonary rehabilitation in multiple occasions both local and overseas. He is the collaborative member of Pulmonary Rehabilitation Council in Asia Pacific region and has been the invited speaker in the Asian Pacific Society of Respirology 2025 meeting.



Dr Desmond Gia-hung NGUYEN

MBBS(HK), MHA (New South Wales),

FRCPsych, FHKAM(Psychiatry), FHKCPsych

Honorary Clinical Associate Professor, Department of Psychiatry, University of Hong Kong

Honorary Clinical Associate Professor, Department of Psychiatry, Chinese University of Hong Kong

Dr Desmond Nguyen was the Hospital Chief Executive of Kwai Chung Hospital between 2019 and 2025. After retirement, he is now working as Psychiatrist in both private and public sector.

Dr Nguyen is an experienced clinician with interest in Consultation Liaison Psychiatry and suicide prevention in clinical setting.



CHAIRPERSONS ►



Dr. Victor Hip-wo YEUNG

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

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

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

Dr. Yeung plays an active role in many medical societies and alumni associations. He is currently the president emeritus of 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).

CHAIRPERSONS ►



Dr. Kwai-ming SIU

*MBChB (CUHK), FHKCOS, FHKAM (Ortho) FRCS Ed (Ortho)
Consultant, Department of Orthopaedics and Traumatology,
Princess Margaret Hospital and North Lantau Hospital*

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 Vice President of The Asian Pacific Orthopaedic Association (Foot & Ankle Section) and Past President of The Hong Kong Orthopaedic Association.

Furthermore, Dr. Siu is the Executive Committee Member of The Federation of Medical Societies of Hong Kong and the Past President of the Hong Kong Foot & Ankle Society. 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.



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*XIGDUO XR is indicated in adults with T2DM and established CV disease or risk factors for CV disease to reduce the risk of hospitalization for heart failure¹. [†]A 24-week, randomized, double-blind, active-controlled study enrolled 638 T2DM patients aged 18 to 77 years, with baseline HbA1c ranging from 7.5 to 12%. The participants were randomly assigned to receive dapagliflozin 10 mg plus metformin XR, dapagliflozin 10 mg alone or metformin XR alone. Metformin was force-titrated in a blinded fashion in 500 mg weekly increments as tolerated, up to 2000 mg daily. The primary endpoint was HbA1c change from BL at 24 weeks². [‡]The DECLARE-TIMI 58: A randomized controlled trial. 17,160 patients with T2DM were randomly assigned in a 1:1 ratio to receive 10 mg of dapagliflozin daily or a matching placebo. 82% were also using metformin as a glucose-lowering drug. The primary safety outcome was MACE (defined as CV death, myocardial infarction, or ischemic stroke). The two primary efficacy outcomes were MACE and a composite of CV death or hospitalization for heart failure³. [§]A sustained decrease in eGFR by at least 40% to less than 60 mL/min/1.73 m², end-stage renal disease, or CV or renal death⁴. ^{††}This was a retrospective cohort study to compare gastrointestinal tolerability of metformin XR tablets with that of metformin IR tablets. A total of 471 patients' charts were reviewed and data were collected from four diabetes clinics⁵. ^{‡‡}A retrospective observational study to examine the adherence and glycemic control in patients prescribed metformin XL (n=137) and IR (n=10,772) preparations⁶.

Abbreviations: AE = adverse event; CI = confidence interval; CV = cardiovascular; eGFR = estimated glomerular filtration rate; FDC = fixed dose combination; GI = gastrointestinal; HbA1c = glycated hemoglobin; HR = hazard ratio; IR = immediate release; MACE = major adverse cardiovascular event; MET = metformin; T2DM = type 2 diabetes; XR = extended release

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