8th ANNUAL MEETING EDM HK

ENDOCRINOLOGY, DIABETES & METABOLISM HONG KONG

25 – 26 OCTOBER 2025 (SAT - SUN)

EXPANDING THE ENDO-VERSE

PROGRAMME BOOK

HKU Med School of Clinical Medicine
Department of Medicine
香港大學內科學系

瑪麗醫院
QUEEN MARY HOSPITAL

K. K. LEUNG DIABETES CENTRE
瑪麗醫院
Queen Mary Hospital
梁銶琚糖尿病中心

STEOPOROSIS CENTRE 骨質疏鬆中心

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WELCOME MESSAGE

Dear Colleagues,

On behalf of the Organizing Committee, we warmly welcome you all to the 8th Annual Meeting of Endocrinology, Diabetes & Metabolism Hong Kong (EDM HK 2025). This meeting is jointly organized by the Department of Medicine, The University of Hong Kong, KK Leung Diabetes Centre and Osteoporosis Centre of Queen Mary Hospital.

"**Expanding the Endo-Verse**" is our theme this year. Our two-day scientific programme features keynote lectures on insulin pumps and its related technologies as well as the management of adrenal incidentalomas including mild autonomous cortisol secretion. In addition, we will have the wonderful opportunity to discuss interesting cases and engage with our distinguished plenary speakers in the 'Meet the Professor' sessions.

EDM HK 2025 is committed to providing a premier platform for practicing clinicians to exchange the latest information and insights on various endocrine diseases, including diabetes, obesity, osteoporosis, thyroid disorders, and other metabolic conditions.

Last but not least, we would like to express our sincere gratitude to all our overseas and local speakers, chairpersons, and sponsors for their contributions and continued support to this meeting. We hope that you will find the programme both fruitful and rewarding.

Dr. Eunice LEUNG
Chairperson
Organizing Committee
8th Annual Meeting of Endocrinology,
Diabetes & Metabolism Hong Kong (EDM HK)

Dr. Chariene WOO
Chairperson
Organizing Committee
8th Annual Meeting of Endocrinology,
Diabetes & Metabolism Hong Kong (EDM HK)

ORAGANIZING COMMITTEE

Chairpersons

Dr. Eunice LEUNG	Dr. Chariene WOO

Conference coordinators

Ms. Tina LAU	Ms. Connie LOONG

Members

Prof. Karen LAM	Prof. Kathryn TAN
Dr. Wing-sun CHOW	Dr. Yu-cho WOO
Prof. Paul LEE	Dr. Alan LEE
Prof. David LUI	Dr. Johnny CHANG
Dr. Lawrence TANG	Dr. Ivan MA
Ms. Karen WONG	Ms. Siu-kuen LEUNG
Ms. Michelle LEE	Ms. Karen LAU

ACCREDITATIONS

CME

Organization	25 October	26 October	Group - category
Hong Kong College of Community Medicine	4	5	PP-PP
Hong Kong College of Family Physicians	3	5	OEA-5.02
The Hong Kong College of Obstetricians and Gynaecologists	TBA	TBA	PP-PN
The College of Ophthalmologists of Hong Kong	3.5	6	CME-PP
Hong Kong College of Orthopaedic Surgeons	3	5	PP-B
Hong Kong College of Paediatricians	3	6	A-PP
Hong Kong College of Pathologists	4	6	CME-PP
Hong Kong College of Physicians	3.5	6	PP-PP
Hong Kong College of Radiologists	3.5	6	B-PP
The College of Surgeons of Hong Kong	4	6	CME-PP
The Medical Council of Hong Kong	TBA	TBA	CME-PASSIVECME
Continuing Pharmacy Education (CPE)	4.5	7.5	N/A

CNE

Organization	25 October	26 October
Continuing Nursing Education (Hong Kong West Cluster)	TBA	TBA

SCIENTIFIC PROGRAMME

25 October 2025 (Saturday)

Time	Room S221	Room S226 – S227
13:00 – 13:30	**Lecture (1)** **Chairperson: Dr. Winston FUNG**	
13:00 – 13:25	**From Prevention to Precision: The Role of Early Intervention in Diabetic Kidney Disease** Prof. Paola FIORETTO (Italy)	
13:25 – 13:30	Q&A	
13:30 – 13:40	**Opening Ceremony**	
13:40 – 14:20	**Plenary Lecture (1)** **Chairperson: Prof. Karen LAM**	
13:40 – 14:15	**Integrating the Avalanche of Diabetes Technologies into Clinical Practice** Prof. Margaret MCGILL (Australia)	
14:15 – 14:20	Q&A	
Time	**Room S221**	**Room S226 – S227**
14:20 – 15:25	**Symposium (1A)** **Chairperson: Prof. Paul LEE and Dr. Maria MAK**	**Symposium (1B)** **Chairperson: Dr. Gloria PANG and Dr. Janus WONG**
14:20 – 14:40	**Updates on the Therapeutic Effects of Exercise on Managing Obesity and Metabolic Syndrome** Prof. Parco SIU (Hong Kong)	**Management of X- linked Hypophosphatemia - Perspective from a Pediatric Endocrinologist** Dr. Yuet-ling TUNG (Hong Kong)
14:40 – 14:45		**Management of X- linked Hypophosphatemia - From An Endocrinologist's Perspective** Dr. Risa OZAKI (Hong Kong)
14:45 – 15:00	**Fasting and Metabolic Health – What Do We Know and How Does It Work?** Prof. Chi-bun CHAN (Hong Kong)	
15:00 – 15:10		**Management of X- linked Hypophosphatemia - Perspective from an Orthopedic Surgeon** Dr. Evelyn KUONG (Hong Kong)
15:10 – 15:20	Q&A	
15:20 – 15:25		Q&A
15:20 – 15:45	**Coffee Break**	
Time	**Room S221**	
15:45 – 16:20	**Lecture (2)** **Chairperson: Dr. Doris CHAN**	
15:45 – 16:15	**Early Initiation of SGLT2i for Cardiorenal Protection** Prof. Cheuk-chun SZETO (Hong Kong)	
16:15 – 16:20	Q&A	
16:20 – 16:50	**Lecture (3)** **Chairperson: Dr. Katherine FAN**	
16:20 – 16:45	**Taking Diabetes to Heart: Value of NT-proBNP in CV Risk Assessment for Diabetes Patients in Asian Populations** Dr. Yong-mong BEE (Singapore)	
16:45 – 16:50	Q&A	
16:50 – 17:20	**Meet the Professor** **Moderators: Dr. Chariene WOO and Ms. Tina LAU**	
16:50 – 17:15	**Tips and Troubleshooting for Pumps and CGMs: What Doctors and Nurses Should Know** Prof. Margaret MCGILL (Australia)	
17:15 – 17:20	Q&A	

SCIENTIFIC PROGRAMME

26 October 2025 (Sunday)

Time	Room S221	Room S226 – S227
09:30 – 10:00	**Lecture (4)** **Chairperson: Dr. Ka-kui LEE**	
09:30 – 09:55	**Second Generation Basal Insulin – Towards A Brighter Future!** Prof. Paul LEE (Hong Kong)	
09:55 – 10:00	Q&A	
10:00 – 10:25	**Coffee Break**	
Time	**Room S221**	**Room S226 – S227**
10:25 – 11:25	**Symposium (2A)** **Chairperson: Dr. Annette TSO and Dr. Tin-wai WONG**	**Symposium (2B)** **Chairperson: Dr. Benjamin AU YEUNG and Dr. Johnny CHANG**
10:25 – 10:50	**Adrenal Insufficiency: Revisiting the Silent Crisis** Dr. Ingrid MAK (Hong Kong)	**Statin Intolerance** Prof. David SIU (Hong Kong)
10:50 – 11:15	**Thyroid Emergency** Dr. Alan LEE (Hong Kong)	**Immune Checkpoint Inhibitor-related Endocrinopathies - Updates in 2025** Prof. David LUI (Hong Kong)
11:15 - 11:25	Q&A	Q&A
Time	**Room S221**	
11:25 – 12:05	**Plenary Lecture (2)** **Chairperson: Prof. Kathryn TAN**	
11:25 – 12:00	**Approach to Patients with Mild Autonomous Cortisol Secretion** Prof. Irina BANCOS (USA)	
12:00 – 12:05	Q&A	
12:05 – 13:05	**Lunch Symposium – Sponsored by Boehringer Ingelheim** **Chairperson: Dr. Yu-cho WOO**	
12:25 – 13:00	**Extended Clinical Insights on SGLT2 Inhibitors: Advancements in Cardiovascular-Kidney-Metabolic Management** Dr. Alice CHENG (Canada)	
13:00 – 13:05	Q&A	
13:05 – 13:40	**Lecture (5)** **Chairperson: Dr. John MA**	
13:05 – 13:35	**A New Era in CKM Care: Harnessing GLP-1 Receptor Agonists for Comprehensive Health Outcomes** Prof. Johannes MANN (Germany)	
13:35 – 13:40	Q&A	
13:40 – 14:15	**Lecture (6)** **Chairperson: Dr. Tellus NG**	
13:40 – 14:10	**Transforming Health Beyond the Weight: Evidence-Based Benefits of GLP-1 Receptor Agonists in Holistic Obesity Management** Prof. Gregory FULCHER (Australia)	
14:10 – 14:15	Q&A	

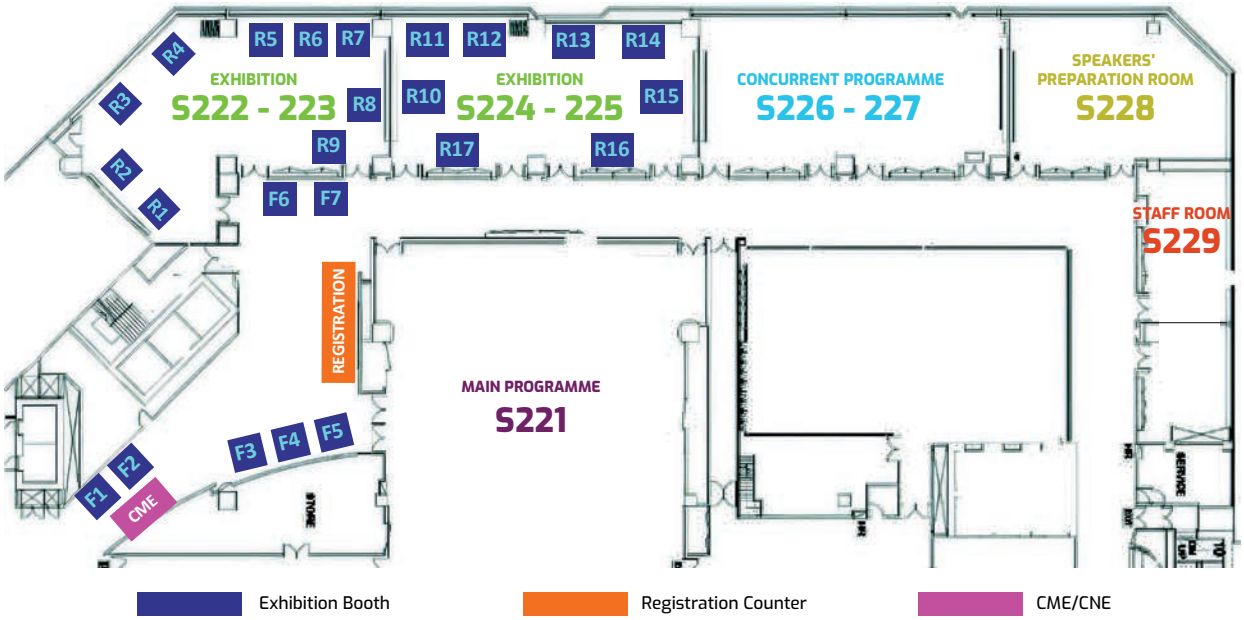
SCIENTIFIC PROGRAMME

26 October 2025 (Sunday)

Time	Room S221
14:15 – 14:45	**Lecture (7)** **Chairperson: Dr. Chun-yip YEUNG**
114:15 – 14:40	**Dilution Dilemma: Tackling SIAD-Related Hyponatremia** Dr. Yu-cho WOO (Hong Kong)
14:40 – 14:45	Q&A
14:45 – 15:10	**Coffee Break**
15:10 - 15:40	**Lecture (8)** **Chairperson: Dr. Joanne LAM**
15:10 - 15:35	**Advances in LDL-C Management: Insights from European Registries** Prof. Ioanna GOUNI-BERTHOLD (Germany)
15:35 - 15:40	Q&A
15:40 - 16:10	**Lecture (9)** **Chairperson: Dr. Michele YUEN**
15:40 - 16:05	**Redefining Obesity Beyond BMI and Elevating the Treatment of Obesity** Prof. Samantha HOCKING (Australia)
16:05 - 16:10	Q&A
16:10 – 16:40	**Meet the Professor** **Moderators: Dr. Alan LEE and Dr. Eunice LEUNG**
16:10 – 16:35	**Navigating the Adrenal Maze: Three Challenging Cases in Diagnosis and Management** Prof. Irina BANCOS (USA)
16:35 – 16:40	Q&A
16:40 – 16:45	**Closing Remarks**

FLOOR PLAN

S221, Level 2, Phase 1 (Old Wing), Hong Kong Convention and Exhibition Centre



LIST OF EXHIBITORS

Organization	Booth Number
Abbott Diabetes Care	R16
Abbott Laboratories Limited	R14
Amgen Hong Kong Limited	R1
Ascensia Diabetes Care Hong Kong Limited	R17
AstraZeneca Hong Kong Limited	F2
Bayer HealthCare Limited	F3
Boehringer Ingelheim (Hong Kong) Ltd.	F4 & F5
Daiichi Sankyo Hong Kong Limited	R8
Eli Lilly Asia, Inc	R12
GlaxoSmithKline Limited	R11
iNova Pharmaceuticals (H.K.) Limited	R10
Ipsen Pharma Hong Kong	R9
JGXZ Company Limited	R7
Medtronic Hong Kong Medical Limited	R2
Merck Pharmaceutical (HK) Ltd.	R5
Novartis Pharmaceuticals (HK) Limited	R6
Novo Nordisk Hong Kong Limited	F6 & F7
Otsuka Pharmaceutical (H.K.) Ltd.	R15
Roche Diagnostics (Hong Kong) Limited	F1
Sanofi Hong Kong Limited	R3
Synmosa Biopharma (HK) Co., Ltd.	R4
Zuellig Pharma Ltd.	R13

LIST OF OVERSEAS SPEAKERS

Prof. Irina BANCOS
Professor of Medicine
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Mayo Foundation for Medical Education and Research (MFMER)
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Prof. Ioanna GOUNI-BERTHOLD
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Center for Endocrinology, Diabetes and Preventive Medicine
The University of Cologne
Germany

Dr. Yong-mong BEE
Head and Senior Consultant
Department of Endocrinology
Singapore General Hospital
Singapore

Prof. Samantha HOCKING
Endocrinologist
Royal Prince Alfred Hospital
Australia

Prof. Alice CHENG
Associate Professor
The University of Toronto
Canada

Prof. Johannes MANN
Professor of Medicine
The University of Erlangen-Nürnberg
Germany

Prof. Paola FIORETTO
Professor
Department of Medicine
The University of Padova
Italy

Prof. Margaret MCGILL
Associate Professor
Faculty of Medicine
The University of Sydney
Australia

Prof. Gregory FULCHER
Chair, Diabetes Community of Practice
New South Wales, Ministry of Health
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SUPPORTING ORGANIZATIONS

香港糖尿科醫士協會
Association of Hong Kong Diabetes Nurses

Diabetes Hongkong

Hong Kong College of Cardiology

香港醫學會
The Hong Kong Medical Association
125 Years

Hong Kong Obesity Society
香港肥胖學會

HKSEMR
Hong Kong Society of Endocrinology, Metabolism and Reproduction

香港兒童內分泌科學會
HKSPEM
The Hong Kong Society of Paediatric Endocrinology and Metabolism

香港復康會
The Hong Kong Society for Rehabilitation

KES
Korean Endocrine Society

澳門內科專科學會
MACAU PHYSICIAN SOCIETY
SOCIEDADE DE MEDICOS ESPECIALISTA DA MEDICINA INTERNA DE MACAU

OSHK
香港骨質疏鬆學會

Youth Diabetes Action
兒童糖尿協會

NOTES

NOTES

Endocrinology Diabetes Metabolism

EDM HK NURSING WORKSHOP 2026

#didactic lectures
#interactive workshop
#case sharing

Stay tuned!

organized by

HKU Med School of Clinical Medicine
Department of Medicine
香港大學內科學系

K. K. Leung Diabetes Centre
瑪麗醫院 Queen Mary Hospital 梁銶琚糖尿病中心

Steoporosis Centre 骨質疏鬆中心

a diabetes and endocrine workshop
specially for nurses

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% RRR[2]

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

Heart failure:

Forxiga reduces the composite risk of hHF, urgent HF visit, and CV death across the range of EF[3]

22% RRR[3]

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 (01/2025)

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FORXIGA XIGDUO XR

AstraZeneca 阿斯利康

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10 YEARS ANNIVERSARY forxiga

One move can change the outcome[1]

For your patients with CKD associated with T2D, intervene now to deliver **dual cardiorenal risk reduction[1]**

Reduce the risk of CV events[1]

Slow CKD progression[1]

Kerendia is the first & only selective, non-steroidal MRA approved to treat CKD in T2D.*[1-3] The impact on serum potassium is manageable.[1]

Why hold back?

*As of 14 Nov 2024.

CKD=chronic kidney disease; CV=cardiovascular; MRA=mineralocorticoid receptor antagonist; T2D=type 2 diabetes.

Reference: 1. Kerendia (finerenone) 10 / 20 mg tablet Hong Kong Prescribing Information (Aug 2023). **2.** American Diabetes Association. Standards of Medical Care in Diabetes. Diabetes Care 2024; 2024;45(Suppl. 1):S1–S321. 3. Drug Office, HKSAR. Available at https://www.drugoffice.gov.hk/eps/drug/productDetail/en/pharmaceutical_trade/140639. Accessed 14 Nov 2024.

Kerendia 10 / 20 mg tablets
Abbreviated Prescribing Information

(Please refer to the full prescribing information before prescribing)

Composition: *Active ingredient:* finerenone. *Excipients*: croscarmellose sodium, hypromellose 5 cP, lactose monohydrate, magnesium stearate, cellulose microcrystalline, sodium laurilsulfate, talc, titanium dioxide, ferric oxide yellow (for 20 mg tablet), ferric oxide red (for 10mg tablet). **Indication:** Delay progressive decline of kidney function and to reduce the risk of cardiovascular mortality and morbidity in adults with chronic kidney disease (with albuminuria) associated with Type 2 diabetes, in addition to standard of care. **Dose and method of administration:** *Recommended target dose:* 20 mg once daily. *Initiation:* Recommended when serum potassium is ≤4.8 mmol/L; may be considered with additional serum monitoring within the first 4 weeks based on patient characteristics and serum potassium levels if serum potassium >4.8 to 5.0 mmol/L; not recommended if serum potassium >5.0 mmol/L or in patients with eGFR <25 mL/min/1.73m². The starting dose is: • 20 mg once daily if eGFR ≥60 mL/min/1.73m² • 10 mg once daily if eGFR ≥25 to <60 mL/min/1.73m². *Continuation:* Four weeks after initiation or re-start or up-titration, remeasure serum potassium and eGFR. Thereafter, remeasure serum potassium periodically and as needed based on patient characteristics and serum potassium levels. **Contraindications** • Taking concomitant medications that are strong CYP3A4 inhibitors • With adrenal insufficiency. **Warnings and precautions:** • Hyperkalaemia. • Avoid concomitant use with potassium-sparing diuretics and other mineralocorticoid receptor antagonists. Used with caution and monitor serum potassium when taken concomitantly with potassium supplements, trimethoprim, or trimethoprim-sulfamethoxazole. • Avoid in patients with severe hepatic impairment (Child Pugh C). Consider additional serum potassium monitoring in patients with moderate hepatic impairment (Child Pugh B). • Initiation of Kerendia treatment is not recommended in patients with eGFR <25 mL/min/1.73m². Continue Kerendia with caution regarding serum potassium levels in patients with end-stage renal disease (eGFR <15 mL/min/1.73m²). • No dose adjustment is required in the elderly. • Kerendia is not recommended in paediatric patients. • Kerendia should not be used during pregnancy unless there has been careful consideration of the benefit for the mother and the risk to the fetus. If the patient becomes pregnant while taking Kerendia, the patient should be informed of potential risks to the fetus. Advise women of childbearing potential to use effective contraception and not to breastfeed during treatment of Kerendia. • Monitor serum potassium especially during initiation of or changes to dosing of Kerendia or a moderate or weak CYP3A4 inhibitor. Avoid concomitant use with strong CYP3A4 inducers, moderate CYP3A4 inducers, or concomitant intake of grapefruit or grapefruit juice. **Undesirable effects:** *Very common (≥10%):* hyperkalaemia. *Common (≥1% to <10%):* hyponatremia, hyperuricemia, hypotension, glomerular filtration rate decreased. For further details, please refer to the full prescribing information (Aug 2023) (MA-M_FIN-HK-0140-1 Apr 2024).

PP-KER-HK-0104-1 11/2024

Bayer HealthCare Limited
14/F Oxford House, Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong
Tel: +852 8100 2755

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Kerendia® finerenone

GO BEYOND LOWERING LDL-C

ADD ON TO REDUCE CV RISK[1,2*]

* Study design: CLEAR OUTCOMES was a double-blind, randomized, placebo-controlled trial involving patients who were unable or unwilling to take statins owing to unacceptable AEs ("statin-intolerant" patients) and had or were at high risk for CVD. Participants were eligible if they had a clinical feature that placed them at high risk for a CV event (30%; n=4,206) or a previous CV event (70%; n=9,764). Patients who were receiving a very low average daily statin dose without unacceptable AEs or other lipid-lowering therapies could be enrolled. A total of 13,970 individuals aged 18 to 85 years were randomly assigned to oral bempedoic acid (180 mg daily, n=6,992) or placebo (n=6,978). Among the patients, 45.6% (n=6,373) had diabetes and 22.7% were taking very low dose statin therapy. The mean LDL-C level at baseline was 3.59 mmol/L for both groups of patients receiving bempedoic acid or placebo. The primary end point was a four-component composite of major adverse CV events, defined as death from CV causes, nonfatal MI, nonfatal stroke, or coronary revascularization.[2]

AEs=adverse events; CV=cardiovascular; CVD=cardiovascular disease; LDL-C=low-density lipoprotein cholesterol; MI=myocardial infarction.

Reference: 1. Parhofer KG, et al. Expert opinion on the integration of combination therapy into the treatment algorithm for the management of dyslipidaemia. Eur Heart J Cardiovasc Pharmacother. 2025: pvaf007; 0,1–13. **2.** Nissen SE, et al. Bempedoic Acid and Cardiovascular Outcomes in Statin-Intolerant Patients. N Engl J Med. 2023;388(15):1353-1364.

Abbreviated prescribing information: Nilemdo

Regulatory Classification (HK): P,S,S_3 **Registration Holder**: Daiichi Sankyo [HK] Ltd. **Composition:** Bempedoic acid 180 mg **Indications:** • Treatment of adults with primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet: in combination with a statin or statin with other lipid-lowering therapies in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin; or alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant, or for whom a statin is contraindicated. • Treatment of adults with established or at high risk for ASCVD to reduce CV risk by lowering LDL-C levels, as an adjunct to correction of other risk factors: in patients on a maximum tolerated dose of a statin with or without ezetimibe; or alone or in combination with ezetimibe in patients who are statin-intolerant, or for whom a statin is contraindicated. **Dosage and administration**: Administer one tablet orally once daily with or without food. Swallow the tablet whole. Coadministration with simvastatin: Limit simvastatin dose to 20 mg daily (or 40 mg for severe hypercholesterolaemia with high CV risk where benefits outweigh risks). **Contraindications**: Hypersensitivity to bempedoic acid or excipients. **Special warnings and precautions for use:** Risk of myopathy with concomitant use of statins: Monitor for unexplained muscle pain, tenderness, or weakness, and elevated CPK. Discontinue treatment if myopathy is confirmed by CPK >10× ULN. Hyperuricemia: May raise uric acid levels and precipitate gout in predisposed patients. Monitor as needed and discontinue if symptomatic. Elevated liver enzymes: Monitor liver function at therapy initiation; discontinue if transaminase elevation >3× ULN persists. Renal impairment: Limited experience in patients with severe renal impairment (eGFR <30 mL/min/1.73 m^2); not studied in patients with ESRD on dialysis. Hepatic impairment: Not studied in patients with severe hepatic impairment (Child-Pugh C). Pregnancy: Not recommended in pregnancy; discontinue if planning pregnancy or in case of pregnancy. Lactation: Breastfeeding is not recommended during treatment. Safety and effectiveness have not been established in paediatric patients. **Adverse reactions:** Common: Anaemia, gout, hyperuricaemia, increased AST, pain in extremity, decreased GFR. **Drug interactions**: Statins: Increases exposure to simvastatin, atorvastatin, pravastatin and rosuvastatin; may raise risk of statin-related myopathy. Transporter-mediated drug interactions: May increase plasma concentrations of OATP1B1/1B3 substrates (bosentan, fimasartan, asunaprevir, glecaprevir, grazoprevir, voxilaprevir, and statins such as atorvastatin, pravastatin, fluvastatin, pitavastatin, rosuvastatin, simvastatin). May increase exposure to OAT2 substrates and weakly inhibit OAT3.

Full local prescribing information is available upon request. Please report Individual Case Safety Report (ICSR)/Adverse Event (AE) to Daiichi Sankyo Hong Kong via pv_hk@daiichisankyo.com.

Abbreviated prescribing information: NUSTENDI

Regulatory Classification (HK): P,S,S_3 **Registration Holder**: Daiichi Sankyo [HK] Ltd. **Composition:** Bempedoic acid 180 mg, ezetimibe 10 mg **Indications:** • Treatment of adults with primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia, as an adjunct to diet: in combination with a statin in patients unable to reach LDL-C goals with the maximum tolerated dose of a statin in addition to ezetimibe; or alone in patients who are either statin-intolerant or for whom a statin is contraindicated, and are unable to reach LDL-C goals with ezetimibe alone; or in patients already being treated with the combination of bempedoic acid and ezetimibe as separate tablets with or without statin. • Treatment of adults with established or at high risk for ASCVD to reduce CV risk by lowering LDL-C levels, as an adjunct to correction of other risk factors: in patients on a maximum tolerated dose of a statin and not adequately controlled with additional ezetimibe treatment; or in patients who are either statin-intolerant, or for whom a statin is contraindicated, and not adequately controlled with ezetimibe treatment; in patients already being treated with the combination of bempedoic acid and ezetimibe as separate tablets. **Dosage and administration**: Administer one tablet orally once daily with or without food. Swallow the tablet whole. Coadministration with bile acid sequestrants: Administer at least 2 hours before or at least 4 hours after bile acid sequestrants. Coadministration with simvastatin: Limit simvastatin dose to 20 mg daily (or 40 mg for severe hypercholesterolaemia with high CV risk where benefits outweigh risks). **Contraindications**: Hypersensitivity to bempedoic acid or excipients. **Special warnings and precautions for use:** Risk of myopathy with concomitant use of statins: Monitor for unexplained muscle pain, tenderness, or weakness, and elevated CPK. Discontinue treatment if myopathy is confirmed by CPK >10× ULN. Hyperuricemia: May raise uric acid levels and precipitate gout in predisposed patients. Monitor as needed and discontinue if symptomatic. Elevated liver enzymes: Monitor liver function at therapy initiation; discontinue if transaminase elevation >3× ULN persists. Renal impairment: Limited experience in patients with severe renal impairment (eGFR <30 mL/min/1.73 m^2); not studied in patients with ESRD on dialysis. Hepatic impairment: Not recommended in patients with moderate or severe hepatic impairment (Child-Pugh B or C). Pregnancy: May cause foetal harm when administered to pregnant women; discontinue in case of pregnancy. Lactation: Breastfeeding is not recommended during treatment. Safety and effectiveness have not been established in paediatric patients. **Adverse reactions:** Common: Anaemia, decreased haemoglobin, hyperuricaemia, decreased appetite, dizziness, headache, hypertension, cough, constipation, diarrhoea, abdominal pain, nausea, dry mouth, flatulence, gastritis, increased liver function test, back pain, muscle spasms, myalgia, pain in extremity, arthralgia, increased blood creatinine, fatigue, asthenia, gout, increased AST, decreased GFR, increased blood CPK. **Drug interactions**: Statins: Increases exposure to simvastatin, atorvastatin, pravastatin and rosuvastatin; may raise risk of statin-related myopathy. Transporter-mediated drug interactions: May increase plasma concentrations of OATP1B1/1B3 substrates (bosentan, fimasartan, asunaprevir, glecaprevir, grazoprevir, voxilaprevir, and statins such as atorvastatin, pravastatin, fluvastatin, pitavastatin, rosuvastatin, simvastatin). May increase exposure to OAT2 substrates and weakly inhibit OAT3. Anticoagulants: INR should be monitored when Nustendi is co-administered with warfarin, other coumarin anticoagulants, or fluindione. Cyclosporin: Monitor cyclosporin concentrations. Fibrates: If cholelithiasis is suspected in a patient receiving Nustendi and fenofibrate, consider alternative lipid-lowering therapy. Cholestyramine: Administer Nustendi either at least 2 hours before or at least 4 hours after bile acid sequestrants.

Full local prescribing information is available upon request. Please report Individual Case Safety Report (ICSR)/Adverse Event (AE) to Daiichi Sankyo Hong Kong via pv_hk@daiichisankyo.com

NILEMDO® (bempedoic acid)

NUSTENDI® (bempedoic acid and ezetimibe)

Daiichi-Sankyo

Daiichi Sankyo Hong Kong Limited
Suites 3207–11, 32/F, Tower One,
Times Square, 1 Matheson Street,
Causeway Bay, Hong Kong

HK-DAI-NN-2507001 Approval Date: Jul 2025

FOR ADULTS WITH OBESITY OR OVERWEIGHT AND A WEIGHT-RELATED COMPLICATION[1]

once weekly
mounjaro®
(tirzepatide) injection

NOW APPROVED FOR WEIGHT MANAGEMENT[1]

Help your patients experience a significant weight loss[1†,‡]

GIP/ GLP-1

Novel mechanism of action[1,2]:
The **first-and-only treatment** activating both **GIP and GLP-1** receptors to target the pathophysiology of obesity.

Powerful weight loss[1,3]:
People taking Mounjaro® **significantly reduced their body weight** by up to an average of 22.5% (23.6 kg).[†,§]

Cardiometabolic improvements[3]:
As demonstrated across key parameters, including **blood pressure, waist circumference, triglycerides, HDL cholesterol,** and **LDL cholesterol.**[‖,¶]

WEIGHT MANAGEMENT

*Hypothetical patient image.

† In SURMOUNT-1 efficacy estimand, the weight loss of Mounjaro® was superior and clinically meaningful compared to placebo (p<0.001). The mean change in weight at end of treatment (week 72) was -16.0% (a reduction of 16.1kg) with Mounjaro® 5-mg dose; -21.4% (a reduction of 22.2kg) with Mounjaro® 10-mg dose; -22.5% (a reduction of 23.6kg) with Mounjaro® 15-mg dose and the mean change with placebo was -2.4% (a reduction of 2.4kg), and included a reduced-calorie diet and increased physical activity.[1,3]

‡ Individual results may vary.

§ Efficacy estimand, MMRM analysis, mITT population (efficacy analysis set).[1,3]

‖ The efficacy estimand for individual doses was not adjusted for multiplicity, with the exception of waist circumference 10 mg and 15 mg.[3]

¶ Mounjaro® is not indicated to reduce cardiometabolic parameters. In SURMOUNT-1 trial, reductions in blood pressure, waist circumference, triglycerides, HDL cholesterol, and LDL cholesterol were secondary endpoints.[1,3]

Mounjaro® was evaluated in a phase 3 trial for 72 weeks. SURMOUNT-1 included 2539 adults with a BMI of ≥30 kg/m^2 or a BMI of ≥27 kg/m^2 and at least 1 weight-related complication, excluding type 2 diabetes. Participants in all arms, including placebo, received instructions for a reduced-calorie diet and increased physical activity. Included were counseling by a dietitian or qualified healthcare professional, a deficit of 500 calories per day, and at least 150 minutes of physical activity per week. Coprimary endpoints (10 mg and/or 15 mg): percentage change in weight from baseline at week 72; percentage of population with weight reduction of ≥5% at week 72. Key secondary endpoints: change from baseline to week 72 in systolic blood pressure, fasting insulin, and lipid levels (triglycerides, HDL cholesterol, non-HDL cholesterol) (all doses combined); percentage of population with weight reduction of ≥10%, ≥15%, and ≥20% at week 72 (10 mg and/or 15 mg); change from baseline to week 72 in waist circumference (10 mg and/or 15 mg); physical function score on the 36-Item Short Form Health Survey (SF-36), version 2, acute form (10 mg and 15 mg); percentage change in body weight from baseline and percentage of population with weight reduction of ≥5% at week 72 (5 mg). Mounjaro® and placebo were administered QW subcutaneously as an adjunct to a reduced-calorie diet and increased physical activity.[1,3]

BMI=body mass index; GIP=glucose-dependent insulinotropic polypeptide; GLP-1=glucagon-like peptide-1; HDL=high-density lipoprotein; LDL=low-density lipoprotein; mITT=modified intent-to-treat; MMRM=mixed model for repeated measures; QW=once weekly.

INDICATION[1]

Mounjaro® is indicated:
1. For the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise:
• as monotherapy when metformin is considered inappropriate due to intolerance or contraindications
• in addition to other medicinal products for the treatment of diabetes.
2. For weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity in adults with an initial Body Mass Index (BMI) of ≥ 30 kg/ m^2 (obesity) or ≥ 27 kg/m^2 to < 30 kg/m^2 (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, prediabetes, or type 2 diabetes mellitus).

SAFETY PROFILE[1,3-9]

Type 2 diabetes mellitus:
In 7 completed phase 3 studies, 5119 patients were exposed to Mounjaro® alone or in combination with other glucose lowering medicinal products. The most frequently reported adverse reactions were gastrointestinal disorders, including nausea (very common), diarrhoea (very common) constipation (common), and vomiting (common). In general, these reactions were mostly mild or moderate in severity and occurred more often during dose escalation and decreased over time.
Weight management:
In 2 completed phase 3 studies, 2519 patients were exposed to Mounjaro® alone or in combination with other glucose lowering medicinal products. The most frequently reported adverse reactions were gastrointestinal disorders, including nausea (very common), diarrhoea (very common), constipation (very common), and vomiting (very common). In general, these reactions were mostly mild or moderate in severity and occurred more often during dose escalation and decreased over time.

Scan to Access the Full Prescribing Information of Mounjaro®

References: 1. Mounjaro® Hong Kong Prescribing Information. **2.** Willard FS, et al. JCI Insight. 2020; 5(17): e140532. **3.** Jastreboff AM, et al. N Engl J Med. 2022;387(3):205-216. **4.** Garvey WT, et al. Lancet. 2023;402(10402):613-626. **5.** Frías JP, et al. N Engl J Med. 2021 Aug 5;385(6):503-515. **6.** Rosenstock J, et al. Lancet. 2021 Jul 10;398(10295):143-155. **7.** Ludvik B, et al. Lancet. 2021 Aug 14;398(10300):583-598. **8.** Del Prato S, et al. Lancet. 2021 Nov 13;398(10313):1811-1824. **9.** Dahl D, et al. JAMA. 2022 Feb 8;327(6):534-545.

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PP-TR-HK-0010 09/2024

Maintaining fluid balance in hyponatremia with SAMSCA®[1]

Thinking One Step Ahead

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

Effective in correcting hyponatremia in CHF and SIADH patients over 24 hours[3]

- Significantly increased the average daily AUC of change from baseline in **serum sodium concentration** vs. placebo[1]*
  - Day 4: 4.0 mEq/L vs. 0.4 mEq/L (p<0.0001)
  - Day 30: 6.2 mEq/L vs. 1.8 mEq/L (p<0.0001)
- Significant effect on **fluid balance in CHF patients** with hyponatremia at Day 1[1]
  - SAMSCA® -1860ml vs. placebo -787ml
- Help **preserving renal function in HF patients** with baseline hyponatremia[4]

*Data based on the pooled-analysis in the placebo-controlled phase 3 hyponatremia trials which enrolled the subjects with euvolemic or hypervolemic hyponatremia[1]

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

References:
1. Integrated Summary of Efficacy of Tolvaptan for the Indication of Hyponatremia (2007). Otsuka Pharmaceutical Development & Commercialization, Inc. 2. SAMSCA® Hong Kong Prescribing Information. Revised Mar 2019. 3. Morris JH, Bohm NM, Nemecek BD, et al. Am J Kidney Dis. 2018 Jun;71(6):772-782. 4. Konstam MA, Gheorghiade M, Burnett JC Jr, et al. JAMA. 2007;297(12):1319-1331.

Abbreviated Prescribing Information

SAMSCA (tolvaptan) 15 mg & 30 mg oral tablets. **INDICATION:** treatment of clinically significant hypervolemic and euvolemic hyponatremia [serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction], including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH). **DOSAGE:** Patients should be in a hospital for initiation and re-initiation of therapy to evaluate the therapeutic response. Too rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) can cause osmotic demyelination. Recommended starting dose: 15 mg once daily. Dosage may be increased at intervals ≥ 24 hr to 30 mg once daily, and to a maximum of 60 mg once daily. Limit use to 30 days to minimize the risk of liver injury. Avoid fluid restriction during the first 24 hours of therapy. **CONTRAINDICATIONS:** Autosomal Dominant Polycystic Kidney Disease; Urgent need to raise serum sodium acutely; Inability of the patient to sense or appropriately respond to thirst; Hypovolemic hyponatremia; Concomitant use of strong CYP 3A inhibitors e.g. clarithromycin, ketoconazole, itraconazole; Anuric patients; Hypersensitivity. **SPECIFIC POPULATIONS:** Only used during pregnancy if potential benefits justify the risk to the fetus. Avoid use in patients with underlying liver disease. Not recommended for patients with CrCl <10 mL/min. **WARNINGS AND PRECAUTIONS:** Avoid coadministration with moderate CYP 3A inhibitors. Too rapid correction of serum sodium can cause serious neurologic sequelae. Liver injury & discontinue treatment when patients develop symptoms indicative of liver injury. Dehydration and Hypovolemia. Co-administration with hypertonic saline not recommended. Avoid co-administration with CYP 3A inducers. Samsca may be increased when co-administered with P-gp inhibitors. Monitor sign of hyperkalemia and cautious when co-administered with drugs that increase serum potassium. **ADVERSE REACTIONS:** Thirst, dry mouth, asthenia, constipation, pollakiuria or polyuria, & hyperglycemia, pyrexia & anorexia. **DRUG INTERACTIONS:** CYP 3A inhibitors, grapefruit juice, P-gp Inhibitors, rifampin and other CYP 3A Inducers, concomitant use increases digoxin AUC/Cmax. **For details, please refer to the full prescribing information which is available upon request.** (Ref: HKPI Revised Mar 2019; Last Update: Oct 2022)Q

Otsuka Otsuka Pharmaceutical (H.K.) Ltd.

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Causeway Bay, Hong Kong
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The only* direct fingerstick NT-proBNP test available at the Point of Care

- **Quick results:** Get reliable results at the Point of Need in only 12 minutes
- **Access to testing:** Readily available on a small, portable instrument almost everywhere
- **Simple workflow:** Simple testing workflow with convenient sampling from capillary blood – no need for phlebotomy
- **Easy storage:** Store at room temperature (2–30°C), no need for refrigeration

Diagnostics. Simplified.
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* as of date – February 3, 2025

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

Toujeo®

From the start, there to help[1]

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

Help your patients get the start they deserve[1]

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

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

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

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

MAT-HK-2300068-1.0-01/2023

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insulin glargine 300U/mL

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10 -CKM
th Anniversary

Jardiance®
(empagliflozin)

A Decade of Transformation in Cardio-Kidney-Metabolic Conditions

Cardiac protection
across LVEF spectrum in HF[1,2]

Kidney protection
in the **broadest CKD population***[3-5]

Metabolic control
as **the only SGLT2i with CV death reduction**†[6-9]

* EMPA-KIDNEY study population included patients with CKD who had an eGFR of ≥20 to <45 ml/min/1.73 m², or who had an eGFR of ≥45 to <90 mL/min/1.73 m² with a UACR of ≥200 mg/g. The primary outcome was a composite of progression of kidney disease (end-stage kidney disease, a sustained eGFR decrease to <10 mL/min/1.73 m², a sustained eGFR decrease of ≥40% from baseline, or death from renal causes) or CV death; 13.1% (432/3,304) in JARDIANCE® group vs 16.9% (558/3,305) in placebo group (hazard ratio 0.72, 95% CI 0.64-0.82, P<0.001). Significant reduction of eGFR decline was observed across all categories of albuminuria.[4] DAPA-CKD study population included CKD patients with an eGFR of 25 to 75 mL/min/1.73 m² and UACR of 200 to 5,000 mg/g.[5]

† The only SGLT2i with CV death reduction in T2DM with eCVD.

Abbreviations: CKD=Chronic kidney disease; CV=Cardiovascular; eCVD=Established cardiovascular disease; eGFR=Estimated glomerular filtration rate; HF=Heart failure; LVEF=Left ventricular ejection fraction; SGLT2i=Sodium-glucose cotransporter 2 inhibitor; UACR=Urine albumin-to-creatinine ratio.

References: 1. Packer M, et al. N Engl J Med 2020;383:1413-1424. **2.** Anker SD, et al. N Engl J Med 2021;385:1451-1461. **3.** Heerspink HJL, et al. Nephrol Dial Transplant 2020;35:274-282. **4.** Herrington WG, et al. N Engl J Med 2023;388:117-127. **5.** Heerspink HJL, et al. N Engl J Med 2020;383:1436-1446. **6.** Zinman B, et al. N Engl J Med 2015;373:2117-2128. **7.** Canagliflozin Hong Kong Prescribing Information. https://www.mims.com/hongkong/drug/info/invokana?type=full. Accessed on 09 May 2025. **8.** Dapagliflozin Hong Kong Prescribing Information. https://www.mims.com/hongkong/drug/info/forxiga?type=full. Accessed on 09 May 2025. **9.** JARDIANCE® Hong Kong Prescribing Information.

Abbreviated Prescribing Information JARDIANCE® (API-JARD-05)

PC-HK-107599 (May 2025)

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