6th Annual Meeting of Endocrinology, Diabetes & Metabolism Hong Kong

EDM HK

28 – 29 October 2023 (Sat – Sun)

Navigating the New Normal

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

In the treatment of patients with type 2 diabetes and established CV disease receiving standard of care,†‡§

CV death can strike at any time

BATTLE CV DEATH NOW MORE THAN EVER§

CV Indication Approved

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

Established HbA1c efficacy[2]

Demonstrated safety profile[1,2]

Convenient, once-daily oral dosing[2]

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

Jardiance®
(empagliflozin)

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

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

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

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

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

Boehringer Ingelheim

Boehringer Ingelheim (HK) Ltd.
Suites 1504-9, Great Eagle Centre, 23 Harbour Road, Wanchai, Hong Kong
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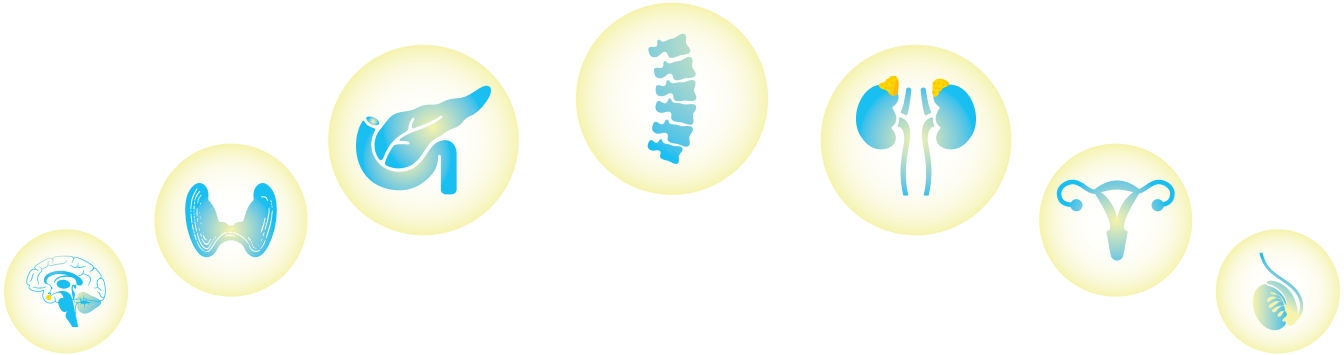
THE ONLY OAD WITH CV INDICATION

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

PC-HK-190806 (Jun 2022)

TABLE OF CONTENTS



WELCOME MESSAGE

Dear Colleagues,

On behalf of the Organizing Committee, we welcome you all to the 6th Annual Meeting of Endocrinology, Diabetes & Metabolism Hong Kong (EDM HK 2023), jointly organized by the Division of Endocrinology, Diabetes and Metabolism, Department of Medicine, The University of Hong Kong, as well as KK Leung Diabetes Centre and Osteoporosis Centre of Queen Mary Hospital.

This exciting and inspiring 2-day scientific programme comprises two plenary lectures on "Current Osteoporosis Guidelines: What Are Missing?" and "Aggressive Pituitary Tumours", as well as state-of-the-art lectures and symposia on a wide range of commonly encountered endocrine disorders such as diabetes, osteoporosis, thyroid conditions, and many others. We are also delighted to introduce our inaugural "Meet the Expert" session, where Dr. Ann McCormack will share with us her expertise and experience in managing various patient scenarios. In addition, "EDM HK Cases of the Year" will also be featured at the meeting, sharing interesting cases which will shed light on our clinical practice.

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

Dr. WS Chow
Chairperson
Organizing Committee
6th Annual Meeting of Endocrinology
Diabetes & Metabolism Hong Kong
(EDM HK 2023)

Ms. Amy SW Yee
Chairperson
Organizing Committee
6th Annual Meeting of Endocrinology
Diabetes & Metabolism Hong Kong
(EDM HK 2023)

ORGANIZING COMMITTEE

Chairpersons

Dr. WS Chow

Ms. Amy SW Yee

Members

Prof. Karen SL Lam

Dr. YC Woo

Dr. Paul CH Lee

Dr. David TW Lui

Dr. Johnny YC Chang

Dr. Lawrence CK Tang

Ms. Karen KC Wong

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Ms. Michelle HY Lee

Prof. Kathryn CB Tan

Dr. TP Ip

Dr. Alan CH Lee

Dr. Eunice KH Leung

Dr. Chariene SL Woo

Dr. KM Ma

Ms. SK Leung

Ms. Tina WT Lau

ACCREDITATIONS

CME				
Organization	**Max. for whole function**	**28 October**	**29 October**	**Group - category**
Hong Kong College of Community Medicine	9	3	6	PP-PP
The Hong Kong College of Family Physicians	TBA	TBA	TBA	OEA-5.02
The Hong Kong College of Obstetricians and Gynaecologists	5	5	5	PP-PN
The College of Ophthalmologists of Hong Kong	TBA	TBA	TBA	CME-PP
Hong Kong College of Orthopaedic Surgeons	8	3	5	PP-B
Hong Kong College of Paediatricians	9	3	6	A-PP
The Hong Kong College of Pathologists	11	4	7	CME-PP
Hong Kong College of Physicians	11	4	7	PP-PP
Hong Kong College of Radiologists	11.5	4	7.5	B-PP
The College of Surgeons of Hong Kong	12	6	6	CME-PP
The Medical Council of Hong Kong	TBA	TBA	TBA	CME-PASSIVE

CNE		
Organization	**28 October**	**29 October**
Hospital Authority Hong Kong West Cluster	4	6.5

SCIENTIFIC PROGRAMME

28 October 2023 (Saturday)

Time	Room S221	Room S226 – S227
	Lecture (1) (Sponsored by GlaxoSmithKline Limited) *Chairperson: Dr. Cheung-hei Choi*	
13:00 – 13:35	**Herpes Zoster and Diabetes: Prevention and Clinical Management Strategies** *Dr. Paul Lee (Hong Kong)*	
13:35 – 13:40	Q & A	
13:40 – 13:50	**Opening Ceremony**	
	Plenary Lecture (1) *Chairperson: Dr. John Ma*	
13:50 – 14:25	**Current Osteoporosis Guidelines: What Are Missing?** *Dr. Tai-pang Ip (Hong Kong)*	
14:25 – 14:30	Q & A	
Time	**Room S221**	**Room S226 – S227**
	Symposium (1A) *Chairperson: Dr. Joanna Tung*	**Symposium (1B)** *Chairperson: Dr. Michele Yuen*
14:30 – 14:55	**Navigating Life After Cancer – Endocrine Disorders in Survivors of Childhood Cancer** *Dr. Sarah Poon (Hong Kong)*	**7 Questions that Physicians Should Ask in Male Subfertility** *Dr. Jason Ng (Hong Kong)*
14:55 – 15:20	**Fertility Preservation: Where Are We Now?** *Dr. Jennifer Ko (Hong Kong)*	**Dermatosis in Endocrinology** *Dr. Mandy Chan (Hong Kong)*
15:20 – 15:30	Q & A	Q & A
15:30 – 16:00	Coffee Break	
Time	**Room S221**	
	Lecture (2) (Sponsored by AstraZeneca Hong Kong Limited) *Chairperson: Dr. Annette Tso*	
16:00 – 16:35	**The Future of the Treatment of Diabetic Kidney Disease** *Professor Hiddo Jan Lambers Heerspink (The Netherlands)*	
16:35 – 16:40	Q & A	
	Lecture (3) (Sponsored by Ipsen Pharma (Hong Kong)) *Chairperson: Dr. Ka-fai Lee*	
16:40 – 17:15	**Interdisciplinary Management of Neuroendocrine Tumor** *Dr. Roland Leung (Hong Kong)*	
17:15 – 17:20	Q & A	
	EDM HK Cases of the Year *Chairperson: Dr. Alan Lee*	
17:20 – 17:30	**A Lady Presented with Thyrotoxic Symptoms and Goitre but Normal TSH** *Dr. Wai-sze Kwan (Hong Kong)*	
17:30 – 17:40	**Breakdown of the Break Down Process - Urea Cycle Disorder** *Dr. Chi-kin Ng (Hong Kong)*	
17:40 – 17:50	**An Unexpected Adrenal Tumour in a Lady with Hypokalemic Hypertension** *Dr. Yuk-kiu Fung (Hong Kong)*	
17:50 – 18:00	**An Unfortunate Case of Pheochromocytoma Crisis** *Dr. Chi-kin Tang (Hong Kong)*	

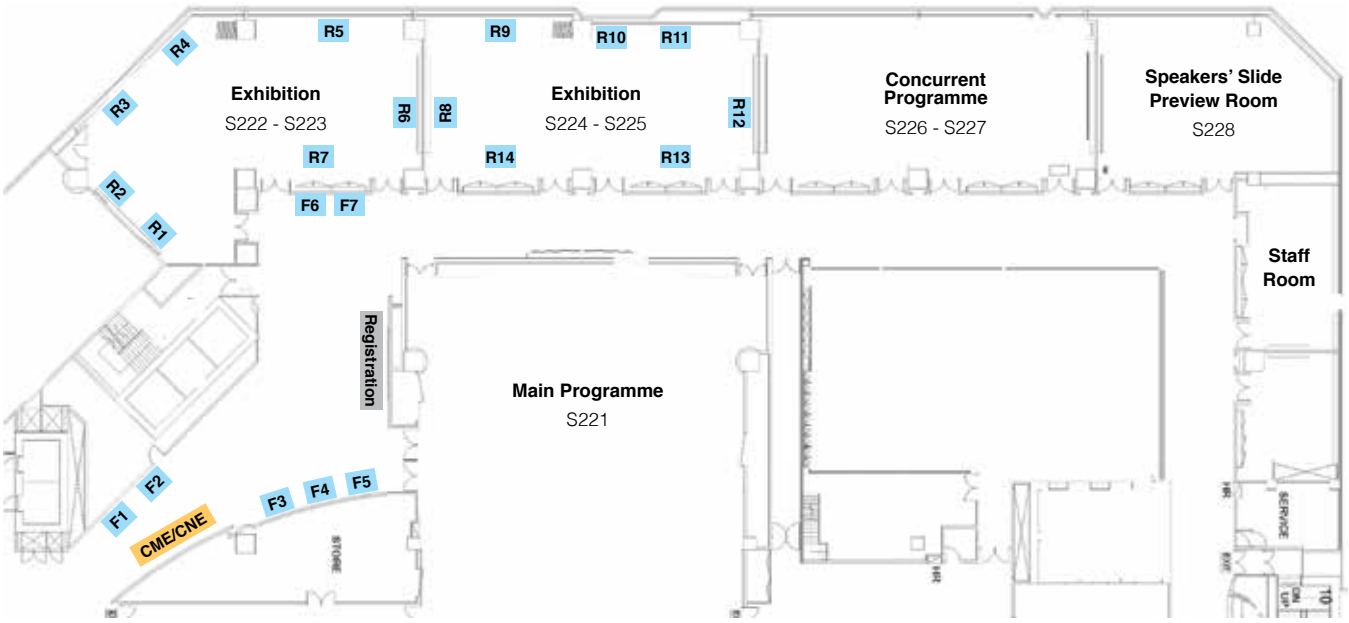
SCIENTIFIC PROGRAMME

29 October 2023 (Sunday)

Time	Room S221	Room S226 – S227
	Lecture (4) (Sponsored by Novo Nordisk Hong Kong Ltd.) *Chairperson: Dr. Victor Hung*	
09:30 – 10:05	**Update of GLP-1RA in T2DM - Real World Evidence and CV Benefits** *Dr. Julie Lovshin (Canada)*	
10:05 – 10:10	Q & A	
10:10 – 10:50	Coffee Break	
Time	**Room S221**	**Room S226 – S227**
	Symposium (2A) *Chairperson: Dr. Doris Chan*	**Symposium (2B)** *Chairperson: Dr. YC Woo*
10:50 – 11:15	**What's New in Thyroid Eye Disease/Graves' Orbitopathy** *Dr. Kelvin Chong (Hong Kong)*	**Glycemic Control in Pregnancy** *Dr. Risa Ozaki (Hong Kong)*
11:15 – 11:40	**Benign Nodular Thyroid Disease: Current Management** *Professor Brian Lang (Hong Kong)*	**AI in Diabetic Retinopathy Management** *Dr. Nicole Chau (Hong Kong)*
11:40 – 11:50	Q & A	Q & A
Time	**Room S221**	
	Plenary Lecture (2) *Chairperson: Professor Karen Lam*	
11:50 – 12:25	**Aggressive Pituitary Tumours** *Dr. Ann McCormack (Australia)*	
12:25 – 12:30	Q & A	
	Diamond Lecture (Sponsored by Boehringer Ingelheim (Hong Kong) Ltd.) *Chairperson: Dr. Grace Kam*	
13:00 – 13:40	**New Insights of SGLT2 Inhibitor: How It Addresses Cardio-renal-metabolic Trio?** *Professor Dirk Müller-Wieland (Germany)*	
13:40 – 13:45	Q & A	
	Lecture (5) (Sponsored by Bayer HealthCare Limited) *Chairperson: Dr. Vicki Tam*	
13:45 – 14:20	**Incorporating Non-steroidal MRA into Clinical Practice for Diabetic Kidney Disease** *Dr. Desmond Yap (Hong Kong)*	
14:20 – 14:25	Q & A	
	Lecture (6) (Sponsored by Eli Lilly Asia, Inc.) *Chairperson: Dr. Chi-kin Yeung*	
14:25 – 15:00	**The Forgotten Incretin: Role of GIP in the Human Body and Type 2 Diabetes** *Dr. David Lui (Hong Kong)*	
15:00 – 15:05	Q & A	
15:05 – 15:35	Coffee Break	
	Lecture (7) (Sponsored by Sanofi Hong Kong Limited) *Chairperson: Dr. Raymond Hue*	
15:35 – 16:10	**Concentrated Insulin, Angel or Devil?** *Dr. Matthew Tan (Singapore)*	
16:10 – 16:15	Q & A	
	Lecture (8) (Sponsored by Daiichi Sankyo Hong Kong Ltd.) *Chairperson: Dr. Joanne Lam*	
16:15 – 16:50	**Novel Oral Non-Statin Lipid Lowering Agent for Hypercholesterolemia Management** *Professor Bryan Yan (Hong Kong)*	
16:50 – 16:55	Q & A	
	Meet the Expert *Chairperson: Dr. Paul Lee*	
16:55 – 17:25	*Dr. Ann McCormack (Australia)*	
17:25 – 17:30	**Closing Remarks**	

FLOOR PLAN

S220, Level 2, Phase 1 (Old Wing), Hong Kong Convention and Exhibition Centre



No. Exhibition Booth Registration Counter CME/CNE

LIST OF EXHIBITORS

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

LIST OF OVERSEAS SPEAKERS

Professor Hiddo Jan Lambers Heerspink
Professor
Department of Clinical Pharmacy and Pharmacology
The University Medical Center Groningen
The Netherlands

Dr. Julie Lovshin
Assistant Professor
Department of Medicine
University of Toronto
Canada

Dr. Ann McCormack
Senior Staff Specialist
Department of Endocrinology
St. Vincent's Hospital
Australia

Professor Dirk Müller-Wieland
Professor of Medicine
Department of Medicine I (Cardiology and Cardiovascular Medicine)
University Hospital in Aachen
Germany

Dr. Matthew Tan
Specialist in Endocrinology
Private Practice
Singapore

LIST OF LOCAL FACULTY

Dr. Doris Chan
Consultant,
Department of
Medicine and Geriatrics,
Pok Oi Hospital

Dr. Mandy Chan
Honorary Clinical
Assistant Professor,
Department of Medicine,
The University of Hong Kong

Dr. Nicole Chau
Associate Consultant,
Department of
Medicine and Geriatrics,
Princess Margaret Hospital

Dr. Cheung-hei Choi
Consultant,
Department of Medicine,
Queen Elizabeth Hospital

Dr. Kelvin Chong
Clinical Associate Professor,
Department of Ophthalmology
and Visual Sciences,
The Chinese University of Hong Kong

Dr. Raymond Hue
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Department of Medicine,
Pamela Youde Nethersole
Eastern Hospital

Dr. Victor Hung
Consultant,
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Medicine and Geriatrics,
Princess Margaret Hospital

Dr. Tai-pang Ip
Consultant,
Department of Medicine,
Tung Wah Hospital

Dr. Grace Kam
Consultant,
Department of
Medicine and Geriatrics,
United Christian Hospital

Dr. Jennifer Ko
Consultant,
Department of
Obstetrics and Gynecology,
Queen Mary Hospital

Dr. Joanne Lam
Honorary Clinical
Assistant Professor,
Department of Medicine,
The University of Hong Kong

Professor Karen Lam
Emeritus Professor of Medicine,
Department of Medicine,
The University of Hong Kong

Professor Brian Lang
Li Shu Fan Medical
Foundation Professor,
Department of Surgery,
The University of Hong Kong

Dr. Alan Lee
Associate Consultant,
Department of Medicine,
Queen Mary Hospital

Dr. Ka-fai Lee
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Department of Medicine,
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Dr. Roland Leung
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Dr. David Lui
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Department of Medicine,
The University of Hong Kong

Dr. John Ma
Specialty in Endocrinology,
Diabetes and Metabolism,
Private Practice

Dr. Jason Ng
Physician In-charge,
Diabetes Centre,
Queen Elizabeth Hospital

Dr. Risa Ozaki
Endocrine Division Head
(Clinical Services),
Department of Medicine,
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LIST OF LOCAL FACULTY

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Resident Specialist,
Hong Kong Children's Hospital

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Adolescent Medicine,
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Private Practice

Professor Bryan Yan
Academic Head,
Department of
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The Chinese University of Hong Kong

Dr. Michele Yuen
Honorary Clinical Assistant Professor,
Department of Medicine,
The University of Hong Kong

ABSTRACT
LECTURE (1) (SPONSORED BY GLAXOSMITHKLINE LIMITED)

Herpes Zoster and Diabetes: Prevention and Clinical Management Strategies

Dr. Paul Lee
Clinical Assistant Professor
Department of Medicine
The University of Hong Kong
Hong Kong

Herpes zoster (HZ) is a viral infection caused by the reactivation of the varicella zoster virus. Patients with diabetes are at significantly higher risks of both HZ due to lower cell-mediated immunity to the virus, as well as post-herpetic neuralgia (PHN), a potential disabling complication of HZ. This talk will provide a comprehensive review of the inter-relationship between HZ and diabetes, the available effective preventive strategies, and discuss the current recommendations with regard to HZ vaccination in patients with diabetes.

ABSTRACT
PLENARY LECTURE (1)

Current Osteoporosis Guidelines: What Are Missing?

Dr. Tai-pang Ip
Consultant
Department of Medicine
Tung Wah Hospital
Hong Kong

The first Osteoporosis Society of Hong Kong (OSHK) Guideline for Clinical Management of Postmenopausal Osteoporosis in Hong Kong was published in 2013. We are very proud to point out that our Guideline was the first among the world to make recommendations on the individualised selection of anti-osteoporosis treatment based on the level of fracture risk of the individual patient with osteoporosis. Bone-forming therapy has already been highlighted in 2013 as one of the initial therapeutic options for patients with established osteoporosis. Our Guideline was also the first to make a recommendation on the optimal duration of bisphosphonate treatment i.e. the decision on the duration of bisphosphonate treatment should be considered on the basis of the risk level of an individual after 5 years of oral or 3 years of intravenous bisphosphonate treatment; treatment should not be stopped for high-risk patients.

Almost all international authorities have revised or updated their osteoporosis management guidelines in recent years since 2020, which essentially involve the adoption of the approach of risk stratification of patients with osteoporosis, and treatment recommendations based on the level of risk categories.

Osteoporosis is a chronic condition that requires long-term management in all patients. Over these years of long-term treatment, there will be inevitable occasions when a switch from one anti-osteoporosis drug to another one is indicated. A switch from pre-existing antiresorptive treatment to a bone-forming drug after an incident fracture may be one of the most common scenarios. However, all the recent guidelines had not provided a clear protocol or advice on the switches among different anti-osteoporosis drugs. In our coming 2023 OSHK Guideline, a special section will be devoted to the switching among the different anti-osteoporosis drugs such that clinicians are provided with a clear recommendation and protocol for switching in order to achieve the best balance in benefits and risks associated with the switch.

ABSTRACT SYMPOSIUM (1A)

Navigating Life After Cancer – Endocrine Disorders in Survivors of Childhood Cancer

Dr. Sarah Poon
Resident Specialist
Hong Kong Children's Hospital
Hong Kong

Advances in childhood cancer treatment have resulted in significant improvement in survival rates. However, by virtue of their disease and its treatments, childhood cancer survivors are at increased risk for a wide range of health problems, including disorders of the endocrine system. Recent data suggest that 40-50% of survivors will develop an endocrine disorder during their lifetime. Risk factors for endocrine disorders include both host (e.g. sex, age) and treatment factors (e.g. radiation dose, chemotherapy regimen, extent of surgery). These endocrinopathies can develop decades following cancer treatment and have substantial adverse impact on physical and psychological well-being of patients. This highlights the importance of regular surveillance with physical examination, clinical history, anthropomorphic measures and laboratory measurements in at-risk survivors.

The goal of this symposium is to review the endocrine effects of childhood cancer especially relating to hypothalamic-pituitary dysfunction, malignancy of the thyroid gland and adverse bone effects. Recommendations addressing the diagnosis and treatment of various endocrine disorders are based on latest international consensus-based guidelines.

ABSTRACT
SYMPOSIUM (1A)

Fertility Preservation: Where Are We Now?

Dr. Jennifer Ko
Consultant
Department of Obstetrics and Gynecology
Queen Mary Hospital
Hong Kong

Fertility preservation is a rapidly expanding field with improving cancer survival rates and the delay in childbearing in modern societies. Gonadal function is compromised by oncological treatment. Fertility preservation refers to the process of saving or protecting eggs, sperms, embryos or ovarian reproductive tissue so that a person can use them to have biological children in the future. The choice of the most appropriate fertility preservation technique for an individual patient depends on many factors. This presentation aims to discuss recent updates in fertility preservation, the provision and regulations of fertility preservation in Hong Kong, with the focus on fertility preservation for medical reasons.

ABSTRACT
SYMPOSIUM (1B)

7 Questions that Physicians Should Ask in Male Subfertility

Dr. Jason Ng
Physician In-charge
Diabetes Centre
Queen Elizabeth Hospital
Hong Kong

Male subfertility, a condition characterized by a man's reduced ability to father a child is getting more common nowadays. It has been estimated at least 30% of infertility is attributed to the male factor solely. Apart from abnormalities in sperm quantity and quality, many factors such as hypogonadism, varicocele, genetic components, urological diseases and environmental factors may play a role for the male subfertility. The consequence of male subfertility is not only about the inability to conceive a child; but also the negative thoughts about self-image, health concern, emotional stress and strained relationship.

Just like other disease, history evaluation and physical examination are mandatory in the assessment of patient with subfertility. Baseline investigations include basic blood tests, hormonal profile and semen analysis. Identifying precise cause is fraught with difficulties because of the co-existence of multiple causative factors and lack of the female partner information.

Treatment option depends on the underlying cause. Hormonal therapy is available for patients with secondary hypogonadism. Surgical intervention may be indicated if there is urological abnormality. Assisted reproductive techniques such as in vitro fertilization can be considered to achieve pregnancy. In conclusion, care of male subfertility has to take into account the multifaceted nature of this problem.

ABSTRACT
SYMPOSIUM (1B)

Dermatosis in Endocrinology

Dr. Mandy Chan
Honorary Clinical Assistant Professor
Department of Medicine
The University of Hong Kong
Hong Kong

Cutaneous manifestations of systemic diseases can manifest in many different forms. In this lecture, we will go through cutaneous manifestations in endocrinological diseases, and interesting rare cases as well. This lecture aims to provide a review of common dermatosis seen at endocrinology clinic, how to recognize it, treatment options, and also cases that should not be missed.

ABSTRACT
LECTURE (2) (SPONSORED BY ASTRAZENECA HONG KONG LIMITED)

The Future of the Treatment of Diabetic Kidney Disease

Professor Hiddo Jan Lambers Heerspink
Professor
Department of Clinical Pharmacy and Pharmacology
The University Medical Center Groningen
The Netherlands

Patients with type 2 diabetes and chronic kidney disease face a high risk of kidney failure, cardiovascular complications and premature death. ACE-inhibitors or Angiotensin Receptor Blockers, sodium glucose co-transporter 2 inhibitors (SGLT2i) and the non-steroidal mineralocorticoid receptor antagonist finerenone are registered and recommended by guidelines to slow CKD progression. Despite the use of these agents, the risk of kidney failure and cardiovascular complications remains high in many patients which is associated with high residual albuminuria. Novel therapies are thus desired to augment kidney and cardiovascular protection.

Several promising combination of novel drugs are currently tested in ongoing clinical trials. The efficacy and safety of GLP-1 receptor agonists and the combined GLP-1/GIP receptor agonist tirzepatide are assessed in phase 3 clinical trials. Post-hoc analyses from cardiovascular safety trials have suggested that these therapies may markedly reduce the progression of kidney function decline. This effect remained present when these agents were added to SGLT2 inhibitors. Other potential promising therapies include aldosterone synthase inhibitors, endothelin receptor antagonists and soluble glucanyl cyclase activators. The challenge for the future will be to tailor the optimal medication (or combination) to each patient.

ABSTRACT
LECTURE (4) (SPONSORED BY NOVO NORDISK HONG KONG LIMITED)

Update of GLP-1RA in T2DM - Real World Evidence and CV Benefits

Dr. Julie Lovshin
Assistant Professor
Department of Medicine
University of Toronto
Canada

Type 2 diabetes mellitus (T2DM) is a chronic metabolic disease that burdens millions of people worldwide.

Adults with T2DM have a significantly higher risk of developing atherosclerotic cardiovascular disease (ASCVD) including peripheral artery disease, myocardial infarction, stroke, and heart failure, affecting approximately one-third of those with T2DM. Importantly, CVD is the leading cause of death amongst adults with T2DM. Adults with T2DM have a 1.5 times greater risk of stroke compared to people without diabetes, and stroke imposes significant morbidity and mortality as well as deteriorating quality of life.

Recently the ADA and ESC highlighted the importance of reducing ASCVD and CV risk in adults withT2DM, providing updated standard of care clinical practice guidelines with prioritized treatment recommendations for those with ASCVD and T2DM. Since some GLP-1RAs have demonstrated both primary and secondary CV protection, some GLP-1RA are recommended as first-line treatment options for reducing CV risk/events independent of glucose control. SUSTAIN 6 was the first cardiovascular outcomes trial to demonstrate that chronic once-weekly treatment with a GLP-1RA (e.g. semaglutide 1.0mg) significantly reduces major cardiovascular events in adults with T2DM with established ASCVD or at high CV risk. In this lecture, we will discuss the updated clinical trial evidence of GLP-1RA in T2DM and CV outcome trials. We will also review real-world evidence with GLP-1RA to evaluate clinical outcomes in real world settings. This lecture aims to provide the most updated scientific knowledge of GLP-1RA in T2DM management for patients with ASCVD or high CV risk.

ABSTRACT
SYMPOSIUM (2A)

What's New in Thyroid Eye Disease/Graves' Orbitopathy

Dr. Kelvin Chong
Clinical Associate Professor
Department of Ophthalmology and Visual Sciences
The Chinese University of Hong Kong
Hong Kong

The Speaker will share the oculoplastic perspectives of a University-Public partnership running the first thyroid eye clinic in Hong Kong. Unique features including "atypical" presentations, disease complications as well as "image & immune-guided management" will be explained using local patient data. Challenges of managing thyroid eye disease by following any recent European/ American consensus and emerging treatment options will also be discussed.

ABSTRACT
SYMPOSIUM (2A)

Benign Nodular Thyroid Disease: Current Management

Professor Brian Lang
Li Shu Fan Medical Foundation Professor
Department of Surgery
The University of Hong Kong
Hong Kong

Nodular thyroid disease is exceedingly common, being palpable in 4% to 7% of the population, and detectable on ultrasound in up to two-thirds of adults. Fortunately, most (>90%) swellings are benign in nature. Identifying certain sonographic features on ultrasound together with fine needle aspiration cytology (FNA) can help to differentiate a benign swelling from a malignant one. No treatment other than regular surveillance is required for cytologically benign, non-hyperfunctioning thyroid nodules that are asymptomatic. Surgery is the standard treatment for nodular thyroid disease that causes clinical symptoms. Surgery normally involves the resection of the affected lobe and isthmus if the swelling is only confined to one lobe. In the last decade, image-guided non-surgical procedures have become increasingly popular in the management of benign thyroid nodules, aiming to relieve of local pressure symptoms. They include chemical ablation with ethanol injection and thermal ablation with laser, radiofrequency, microwaves, and high intensity focused ultrasounds. However, the long-term follow-up of these procedures is still limited (up to 5 years in most series) and in 10% of the cases, a partial regrowth of the nodule occurs, warranting further treatment. Therefore, careful patient selection, counselling, and consent, combined with sound technical skills and knowledge, are essential for optimization of long-term results.

ABSTRACT
SYMPOSIUM (2B)

Glycemic Control in Pregnancy

Dr. Risa Ozaki
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Prince of Wales Hospital
Hong Kong

Diabetes is one of the most common medical conditions complicating pregnancy. The prevalence is rising and correlates with the increase in maternal obesity in recent decades. Hyperglycaemia in pregnancy confers significant risk to both mother and fetus including spontaneous abortion, fetal anomalies, pre-eclampsia, macrosomia and fetal demise. These risks can be reduced by improving pre-conception counselling and antenatal care through a multidisciplinary approach bringing together the expertise of obstetrician, endocrinologist, ophthalmologist, diabetes nurse educator and dietician. All women with diabetes of reproductive potential should be informed of the importance of achieving and maintaining as near euglycaemia as safely possible, prior to and throughout pregnancy. With pre-conception planning, optimization of glycaemic control with the switch to pharmacological therapy safe in pregnancy, prior to conception would improve pregnancy outcome. Insulin is the preferred treatment of choice for diabetes in pregnancy. An RCT of metformin added to insulin for diabetes treatment in pregnancy showed less maternal weight gain and Cesarean births due to fewer macrosomic neonates. However, a doubling of small for gestational age neonates was observed.

In this talk an outline on the important components of diabetes care in pregnancy will be addressed, from the point of pre-conception counselling to antenatal care and post-partum care to optimize pregnancy outcome.

ABSTRACT
SYMPOSIUM (2B)

AI in Diabetic Retinopathy Management

Dr. Nicole Chau
Associate Consultant
Department of Medicine and Geriatrics
Princess Margaret Hospital
Hong Kong

Diabetic retinopathy (DR) is the leading cause of new case blindness and visual loss among adults in Hong Kong. It is important to diagnose DR at an early stage, as prompt treatment results in the best prognosis. Eye assessment with DR grading is an integral part of Diabetes Comprehensive Assessment (DCA) to screen for diabetes-related eye pathologies. Recent development of Artificial intelligence (AI)-based algorithms to detect DR from retinal images has incorporated machine learning into these algorithms to improve diagnostic accuracy. Integration of AI model into DR assessment workflow can improve service quality and enhance efficiency in identifying high risk groups for early treatment. In the past few years, the Hospital Authority has developed an AI model for DR grading for integration into clinical workflow using international datasets and local fundus images in Clinical Management System (CMS). By uploading digital fundus photos to CMS and interfacing to Artificial Intelligence and Data Analytics (AIDA) platform, generation of AI report can support clinical decisions and aid demand side management at busy clinics.

Keywords for searching: Diabetes mellitus (DM)/ Diabetes care/ Glycemic control/ Diabetic retinopathy (DR)/ Artificial intelligence (AI)/ Machine learning/ Clinical Management System (CMS)/ Artificial intelligence and data analytics (AIDA)

ABSTRACT
PLENARY LECTURE (2)

Aggressive Pituitary Tumours

Dr. Ann McCormack
Senior Staff Specialist
Department of Endocrinology
St. Vincent's Hospital
Australia

Aggressive pituitary tumours (APT), as defined by the 2018 European Society of Endocrinology Clinical Practice Guidelines, are invasive tumours with an unusually rapid tumour growth rate or clinically relevant growth despite optimal standard therapies[1]. A small subset may progress to become pituitary carcinomas, when cerebrospinal or systemic metastases, are demonstrated. These tumours commonly evolve over a number of years and given the complexity of care they need to be recognised and involve guidance from an expert pituitary multidisciplinary team. Over the last decade significant advances in the management of these tumours has emerged. Temozolomide remains the first-line chemotherapy with second line therapy options including immune checkpoint inhibitors, anti-VEGF and other targeted therapies as well as peptide receptor radionuclide therapy. Timing of radiotherapy with oncological therapies is increasingly important. Many challenges remain such as patient selection, duration of therapy and predicting response to therapeutic options. Where available, tumour molecular testing can help guide management and may facilitate patient recruitment into clinical trials.

[1] Raverot G, Burman P, **McCormack A**, Heaney A, Petersenn S, Popovic V et al. *European Society of Endocrinology Clinical Practice Guidelines for the management of aggressive pituitary tumours and carcinomas*. Eur J Endocrinol. 2018;178(3):265-76.

ABSTRACT
DIAMOND LECTURE (SPONSORED BY BOEHRINGER INGELHEIM (HONG KONG) LTD.)

New Insights of SGLT2 Inhibitor: How It Addresses Cardio-renal-metabolic Trio?

Professor Dirk Müller-Wieland
Professor of Medicine
Department of Medicine I (Cardiology and Cardiovascular Medicine)
University Hospital in Aachen
Germany

Sodium-glucose co-transporter 2 (SGLT2) inhibitors have emerged as a promising class of drugs with cardiorenal benefits in patients with type 2 diabetes and heart failure. These inhibitors not only lower blood glucose levels but also exhibit additional effects on the cardiovascular and renal systems. Numerous clinical trials have demonstrated their cardioprotective effects, reducing the risk of major adverse cardiovascular events. Additionally, SGLT2 inhibitors have shown efficacy in improving renal outcomes by slowing the progression of kidney disease and reducing cardiovascular-related mortality.

This lecture will provide the robust evidence from these trials which has prompted international diabetes treatment guidelines to prioritize the use of SGLT2 inhibitors over other antihyperglycemic therapies, particularly in patients with established cardiovascular disease, heart failure, or chronic kidney disease. However, practical considerations must be taken into account when prescribing SGLT2 inhibitors. Monitoring renal function, assessing volume status, and addressing the risk of potential adverse events, such as urinary tract infections and genital mycotic infections, are crucial aspects of their use. By understanding the latest clinical evidence, practical implications, and guideline recommendations, healthcare professionals can make informed decisions about incorporating SGLT2 inhibitors into the management of patients with cardio-renal-metabolic conditions.

ABSTRACT
LECTURE (5) (SPONSORED BY BAYER HEALTHCARE LIMITED)

Incorporating Non-steroidal MRA into Clinical Practice for Diabetic Kidney Disease

Dr. Desmond Yap
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Department of Medicine
The University of Hong Kong
Hong Kong

Diabetic kidney disease (DKD) is a leading cause of chronic kidney disease (CKD) and end-stage kidney disease (ESKD) in the local and global perspective. The management of DKD has evolved significantly over the past two decades, moving from the use of renin-angiotensin-aldosterone (RAAS) blockade to the recent application of SGLT2 inhibitors. Despite the institution of RAAS blockade and SGLT2 inhibitors, a significant proportion of diabetic patients still show renal function deterioration and ESKD, and therefore treatments that can further attenuate the risk of CKD progression are eagerly awaited. One difficulty in managing DKD is related to its complex pathogenesis. Suboptimal glycaemic control, accumulation of advanced glycation end-products (AGE), disturbances in systemic and intra-renal haemodynamics, and inflammation and fibrosis all contribute to the development and progression of DKD. Existing treatments largely focus on optimising glycaemic profiles and blood pressure control, improving intra-glomerular haemodynamics and hyperfiltration status; but therapeutic options that can target inflammatory and fibrotic processes remains limited. Emerging evidence has suggested that mineralocorticoid receptor antagonists (MRAs) can alleviate inflammation and fibrosis in DKD. In this context, non-steroidal MRAs (e.g. finerenone) shows distinct pharmacokinetics profiles compared with conventional steroidal MRAs, and hence has clear advantages on efficacy and side effects profile. Results from multi-centre randomized controlled trials showed that finerenone can significantly reduce the risk of composite kidney outcomes compared with placebo, and such benefits were irrespective of the baseline eGFR and proteinuria status. Other beneficial effects of finerenone include decrease in proteinuria and the risk of adverse cardiovascular outcomes. The overall tolerability of non-steroidal MRAs was good, with minimal impact on sexual side effects and hyperkalaemia. The addition of non-steroidal MRAs to patients receiving SGLT2 inhibitors also appear to be safe and confer even more reduction in proteinuria. With these renal and cardiovascular benefits, non-steroidal MRA have emerged as a novel and useful treatment in the armamentarium of DKD management.

ABSTRACT
LECTURE (6) (SPONSORED BY ELI LILLY ASIA, INC.)

The Forgotten Incretin: Role of GIP in the Human Body and Type 2 Diabetes

Dr. David Lui
Clinical Assistant Professor
Department of Medicine
The University of Hong Kong
Hong Kong

The incretin effect refers to the phenomenon of greater stimulation of insulin secretion with oral glucose than intravenous glucose, even when the glycaemic excursion is similar. It plays a significant role in the maintenance of euglycaemia. Glucose-dependent insulinotropic peptide (GIP) and glucagon-like peptide-1 (GLP-1) are the incretin hormones responsible for this effect. The incretin effect is substantially attenuated in type 2 diabetes and represents a therapeutic target. The focus over the last two decades has been mainly on GLP-1. In contrast, GIP has received far less attention because initial short-term studies showed that exogenous GIP barely stimulated insulin secretion in individuals with type 2 diabetes. GIP has been thought to be 'obesogenic' as GIP receptor-deficient mice are lean and protected from diet-induced obesity. Furthermore, GIP can stimulate glucagon, unlike GLP-1 which suppresses glucagon secretion. These have led to a shift of focus to developing GLP-1 receptor agonists.

However, the interest in the therapeutic potential of GIP in type 2 diabetes has been rekindled with results from recent studies. In this symposium, the potential important role of this 'forgotten' incretin in health and disease will be discussed, including the intriguing effects of GIP in the brain and adipose tissue.

ABSTRACT
LECTURE (7) (SPONSORED BY SANOFI HONG KONG LIMITED)

Concentrated Insulin, Angel or Devil?

Dr. Matthew Tan
Specialist in Endocrinology
Private Practice
Singapore

Since 1921, insulin has continued to provide a major stimulus for scientific research, with the landscape of insulin continually evolving[1,2]. The evolution of basal insulin starts from neutral protamine Hagedorn (NPH) to 1st generation basal insulin analogs, insulin glargine 100 units/mL (Gla-100) and insulin detemir, and further into 2nd generation basal insulin analogs (Gla-300 and insulin degludec)[1,2].

By using a concentrated 2nd generation basal insulin, such as Gla-300, patients could receive reduced injection volume compared to using Gla-100 when using the same injection unit[3-5]. The injection depot size of Gla-300 is also reduced which allows an increase in the duration of action compared to Gla-100[3-5]. The concentrated basal insulin offers a more stable and long-lasting pharmacokinetic and pharmacodynamic profile which results in a reduced risk of hypoglycaemia compared with Gla-100[5,6].

A correct dosing regimen and a simple method of switching are vital to both clinicians and patients in the starting of 2nd generation basal insulin. For Gla-300 and Gla-100, the starting dose is identical for insulin naive patients[7]. Switching from once daily Gla-100 to Gla-300 should follow a 1:1 unit conversion.

This lecture will cover the overview and latest data on 2nd generation basal insulin, particularly focusing on Gla-300, switching from 1st generation basal insulin to 2nd generation basal insulin, the unmet need in the patients, and recent international diabetes recommendations.

Reference:

1. Hirsch IB, et al. Endocr. Rev 2020;(41)5:733–755
2. Vecchio I, et al. Front. Endocrinol 2018;9:613
3. Dailey G, Lavernia F. Diabetes Obes Metab. 2015 Jul 3. doi: 10.1111/dom.12531.
4. Steinstraesser A et al. Diabetes Obes Metab. 2014;16:873-6
5. Becker RH, et al. Diabetes Care 2015;38:637–643
6. Francisco J, et al. Diabetes Care 2020;43:1242–1248
7. Toujeo Hong Kong prescribing information (approved by the Hong Kong Department of Health as of 16 Oct 2023)

ABSTRACT
LECTURE (8) (SPONSORED BY DAIICHI SANKYO HONG KONG Ltd.)

Novel Oral Non-Statin Lipid Lowering Agent for Hypercholesterolemia Management

Professor Bryan Yan
Academic Head
Department of Medicine and Therapeutics
The Chinese University of Hong Kong
Hong Kong

Despite the availability of different classes of lipid-lowering therapies in the market, the combination use of such therapies has not been fully utilized. Lipid management remains a significant challenge in the prevention of atherosclerotic cardiovascular disease (ASCVD). A considerable number of high-risk and very high-risk patients fail to maintain their LDL-C levels below 1.8 mmol/L and 1.4 mmol/L, respectively, as suggested by the ESC guidelines.

There is a gap for an LDL-C lowering therapy that could improve adherence and provide cardiovascular benefits. Bempedoic acid is a non-statin, oral ATP-citrate lyase (ACL) inhibitor that is a pro-drug primarily activated in the liver but not in skeletal muscles. It could reduce LDL-C levels by 17 - 24% alone and 38% when used in a fixed-dose combination with Ezetimibe. Throughout the bempedoic acid CLEAR program, muscle-related side effects observed in the bempedoic acid arm were comparable to those in the placebo arm. The Landmark CLEAR Outcomes trial also demonstrated that bempedoic acid monotherapy reduced the incidence of major cardiovascular events by 13% compared to placebo in statin-intolerant patients. This lecture will discuss the efficacy and safety of bempedoic acid observed in the CLEAR program, along with the expected clinical application of bempedoic acid in Hong Kong.

SUPPORTING ORGANIZATIONS

香港糖尿科護士協會
Association of Hong Kong Diabetes Nurses

Diabetes Hongkong

Hong Kong Obesity Society
香港肥胖學會

HKPDA

香港醫學會
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The Hong Kong Society
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HKSPEM
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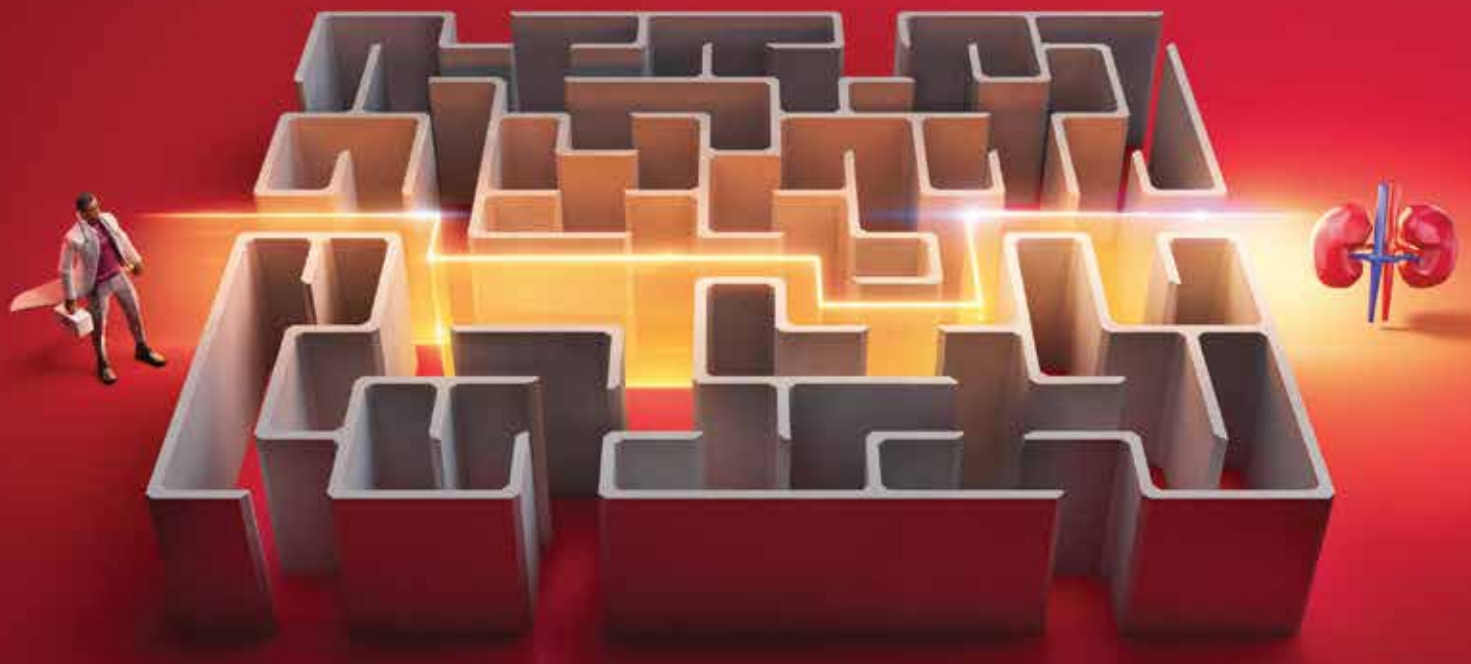
- Manageable impact on serum potassium[1,4]
- Included in 2022 ADA and KDIGO Guidelines with level A evidence[2,5]

Delay CKD progression with Kerendia[1]



* As of 9 Jan 2023

ADA=American Diabetes Association; CKD=chronic kidney disease; CV=cardiovascular; KDIGO=Kidney Disease Improving Global Outcomes; MRA=mineralocorticoid receptor antagonist; T2D=type 2 diabetes.

References: 1. Kerendia 10 / 20 mg film-coated tablets Hong Kong prescribing information (July 2022). **2.** Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group. Kidney Int. 2022;102(5S):S1-S127. **3.** Drug Office, HKSAR. Available at: https://www.drugoffice.gov.hk/eps/drug/productDetail/en/pharmaceutical_trade/140639. Accessed 9 Jan 2023. **4.** Bakris GL, et al; N Engl J Med. 2020;383:2219-2229. **5.** American Diabetes Association Professional Practice Committee. Diabetes Care. 2022;45(Suppl_1):S175-S184.

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 in adults with chronic kidney disease associated with Type 2 diabetes (with albuminuria), 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/1.73m^2 . The starting dose is: • 20 mg once daily if eGFR ≥60 mL/min/1.73m^2 • 10 mg once daily if eGFR ≥25 to <60 mL/min/1.73m^2. *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/1.73m^2 . Continue Kerendia with caution regarding serum potassium levels in patients with end- stage renal disease (eGFR <15 mL/min/1.73m^2). • 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 foetus. If the patient becomes pregnant while taking Kerendia, the patient should be informed of potential risks to the foetus. 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, hypotension, glomerular filtration rate decreased. For further details, please refer to the full prescribing information (July 2022) (MA-M_FIN-HK-0074-1 Dec 2022).

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* Avoid concomitant use of Nilemdo®/Nustendi® with simvastatin >20 mg, or with pravastatin >40 mg.[1,2]
† vs placebo on top of maximally tolerated statins, with or without other oral lipid-lowering therapies. An up to 17% LDL-C reduction on top of maximally-tolerated statin therapy with around 50% of studied patients on high intenisty statins.[3] An up to 28% LDL-C reduction was observed in patients on no statin, very low-intensity or low-intensity statin therapy, with or without other non-statin lipid lowering therapies[5,6]
‡ vs placebo on top of maximally tolerated statins.[7]

References:
1. Nilemdo Hong Kong Package Insert Mar 2023. **2.** Nustendi Hong Kong Package Insert Mar 2023. **3.** Goldberg AC et al. *JAMA*. 2019; 322(18): 1780-1788. **4.** Ray KK et al. *N Engl J Med*. 2019; 380: 1022-1032. **5.** Laufs U et al. *J Am Heart Assoc*. 2019; 8:e011662. **6.** Ballantyne CM et al. *Atherosclerosis*. 2018; 277: 195-203. **7.** Ballantyne CM et al. *Eur J Prev Cardiol*. 2020; 27(6): 593-603.

LDL-C: low-density lipoprotein cholesterol.

Abbreviated Prescribing Information
Nilemdo (bempedoic acid) tablets 180 mg. **Indications:** Nilemdo is an adenosine triphosphate-citrate lyase (ACL) inhibitor indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C. **Dosage and Administration:** Administer 180 mg orally once daily with or without food. **Contraindications:** None. **Warnings and Precautions:** *Hyperuricemia:* May increase blood uric acid levels. Assess uric acid levels periodically as clinically indicated. Monitor for signs and symptoms of hyperuricemia, and initiate treatment with urate-lowering drugs as appropriate. *Tendon Rupture:* Nilemdo is associated with an increased risk of tendon rupture or injury. Discontinue Nilemdo at the first sign of tendon rupture. Avoid Nilemdo in patients who have a history of tendon disorders or tendon rupture. Pregnancy and lactation. **Adverse Reactions:** *Most common:* upper respiratory tract infection, muscle spasms, hyperuricemia, back pain, abdominal pain or discomfort, bronchitis, pain in extremity, anemia, and elevated liver enzymes. Others include tendon rupture, gout, benign prostatic hyperplasia, atrial fibrillation. **Drug Interactions:** *Simvastatin:* Avoid concomitant use of Nilemdo with simvastatin greater than 20 mg. *Pravastatin:* Avoid concomitant use of Nilemdo with pravastatin greater than 40 mg. Version: Mar 2023.

Nustendi (bempedoic acid and ezetimibe) tablets 180 mg bempedoic acid/10 mg ezetimibe. **Indications:** Nustendi is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C. **Dosage and Administration:** Administer one tablet (180 mg bempedoic acid and 10 mg ezetimibe) 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. **Contraindications:** Known hypersensitivity to ezetimibe tablets. **Warnings and Precautions:** *Hyperuricemia:* May increase blood uric acid levels. Assess uric acid levels periodically as clinically indicated. Monitor for signs and symptoms of hyperuricemia, and initiate treatment with urate-lowering drugs as appropriate. *Tendon Rupture:* Increased risk of tendon rupture or injury. Discontinue Nustendi at the first sign of tendon rupture. Avoid Nustendi in patients who have a history of tendon disorders or tendon rupture. Pregnancy and lactation. **Adverse Reactions:** *Most common:* upper respiratory tract infection, muscle spasms, hyperuricemia, back pain, abdominal pain or discomfort, bronchitis, pain in extremity, anemia, elevated liver enzymes, diarrhea, arthralgia, sinusitis, fatigue, and influenza. Others include tendon rupture, gout, benign prostatic hyperplasia, atrial fibrillation. **Drug Interactions:** *Simvastatin:* Avoid concomitant use of Nustendi with simvastatin greater than 20 mg. *Pravastatin:* Avoid concomitant use of Nustendi with pravastatin greater than 40 mg. *Cyclosporine:* Monitor cyclosporine 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. Version: Mar 2023.

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CDC = Centers for Disease Control and Prevention

Indication: SHINGRIX is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older; and 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 is for intramuscular injection only, preferably in the deltoid muscle. The vaccine is given as a 2-dose series. The second dose can be administered as soon as 2 months after the first dose (and if necessary, anytime between 2-6 months). In adults aged 50 years or above, the most frequently reported adverse reactions include pain at the injection site, myalgia, fatigue and headache. Most of these reactions were not long-lasting. In adults 18 years or above who are immunodeficient or immunosuppressed due to disease or therapy (referred to as immunocompromised (IC)), the safety profile was consistent with that observed in adults 50 years and above. There are limited data in adults aged 18-49 years at increased risk of HZ who are not IC.

Abbreviated Prescribing Information

Name of the Medicinal Product: Shingrix vaccine powder and suspension for suspension for injection. Herpes zoster vaccine (recombinant, adjuvanted) Qualitative and Quantitative Composition: After reconstitution, 1 dose (0.5 ml) contains 50 micrograms of gE antigen adjuvanted with AS01B. Varicella Zoster Virus (VZV) glycoprotein E (gE) produced by recombinant DNA technology in Chinese Hamster Ovarian (CHO) cells. The GlaxoSmithKline proprietary AS01B Adjuvant System is composed of the plant extract Quillaja saponaria Molina, fraction 21 (QS-21) (50 micrograms) and 3-O-desacyl-4'-monophosphoryl lipid A (MPL) from Salmonella minnesota (50 micrograms) Indications: Shingrix is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older and adults 18 years of age or older at increased risk of HZ. Posology and Administration: The primary vaccination schedule consists of two doses of 0.5 ml each: an initial dose followed by a second dose 2 months laterFor subjects who are or might become immunodeficient or immunosuppressed due to disease or therapy, and whom would benefit from a shorter vaccination schedule, the second dose can be given 1 to 2 months after the initial dose Method of administration: Intramuscular injection. Contraindications: Hypersensitivity to the active substances or to any component of the vaccine. Special Warnings and Precautions for Use: As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following the administration of the vaccine. As with other vaccines, vaccination with Shingrix should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination. As with any vaccine, a protective immune response may not be elicited in all vaccinees. Do not administer the vaccine intravascularly or intradermally. Subcutaneous administration is not recommended. Maladministration via the subcutaneous route may lead to an increase in transient local reactions. Shingrix should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following intramuscular administration to these subjects. Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints. Interactions: Shingrix can be given concomitantly with unadjuvanted inactivated seasonal influenza vaccine, 23-valent pneumococcal polysaccharide vaccine (PPV23) or reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa). The vaccines should be administered at different injection sites. Fertility, pregnancy and Lactation: Pregnancy: There are no data from the use of Shingrix in pregnant women. The effect on breast-fed infants of administration of Shingrix to their mothers has not been studied. Undesirable effects: lymphadenopathy, hypersensitivity reactions including rash, urticaria, angioedema, headache, gastrointestinal symptoms (including nausea, vomiting, diarrhoea and/or abdominal pain), myalgia, arthralgia, injection site reactions (such as pain, redness, swelling), fatigue, chills, fever, injection site pruritus, malaise. Incompatibility: This medicinal product must not be mixed with other medicinal products. Use and handling: The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine. Shingrix must be reconstituted prior to administration. 1. Withdraw the entire contents of the vial containing the suspension into the syringe. 2. Add the entire contents of the syringe into the vial containing the powder. 3. Shake gently until the powder is completely dissolved. The reconstituted vaccine is an opalescent, colourless to pale brownish liquid. The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not administer the vaccine. After reconstitution, the vaccine should be used promptly; if this is not possible, the vaccine should be stored in a refrigerator (2°C – 8°C). If not used within 6 hours it should be discarded. Before administration: 1. Withdraw the entire contents of the vial containing the reconstituted vaccine into the syringe. 2. Change the needle so that you are using a new needle to administer the vaccine. Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong. Abbreviated Prescribing Information prepared in 26 May 2022 based on version HK072021(GDS04/EMA20210311).

References: 1. Centers for Disease Control and Prevention. MMWR. 2018 Jan;67(3):103-8. 2. GSK. SHINGRIX Hong Kong Prescribing Information GDS04. 3. MSD Live-attenuated Zoster Vaccine Product Circular.

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 at GSK, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, HK.

PM-HK-SGX-ADVT-220001 (05/2024) Date of preparation: 01/06/2022

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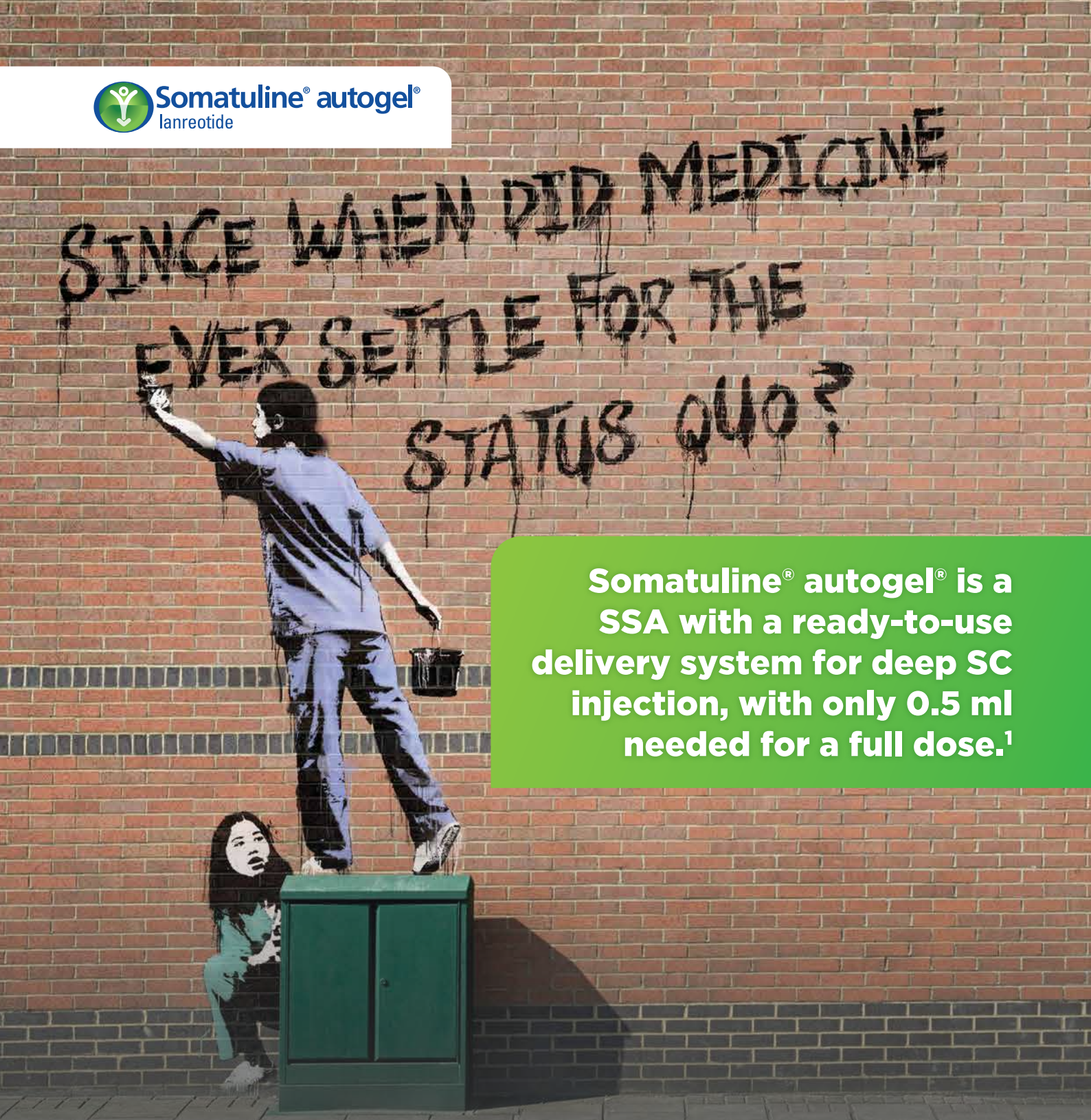
GSK

Somatuline® autogel®
lanreotide



Somatuline® autogel® is a SSA with a ready-to-use delivery system for deep SC injection, with only 0.5 ml needed for a full dose.[1]

Abbreviations: SC, subcutaneous; SSA, somatostatin analog

Reference: 1. Hong Kong Somatuline Autogel Package Insert (approved 15th July, 2021).

Somatuline® Abridged Prescribing Information
Trade Name: Somatuline® Autogel® 60, 90, 120 mg prolonged-release solution for injection in a prefilled syringe. **Posology & Administration:** The solution should be injected via the deep sub-cutaneous route in the superior external quadrant of the buttock. The decision of administration by the patient or another trained person should be taken by the healthcare professional. Acromegaly: recommended dose is 60 to 120 mg every 28 days. Carcinoid tumors: recommended starting dose is 90 mg every 28 days during 2 months, and then to be adjusted in specialized unit. Gastroenteropancreatic neuroendocrine tumors: recommended dose is 120 mg every 28 days, treatment should be continued as long as needed for tumour control. **Contraindications:** Hypersensitivity to somatostatin or related peptides or to any of the excipients. Special Warnings & Precautions: Lanreotide may reduce gallbladder motility and lead to gallstone formation. Patients may need to be monitored periodically. Pharmacological studies in animals and humans showed that lanreotide inhibits secretion of insulin and glucagon. Blood glucose levels should be monitored when lanreotide treatment is initiated, or when the dose is altered. Any antidiabetic treatment should be adjusted accordingly. Slight decreases in thyroid function have been seen during treatment with lanreotide in acromegalic patients. Thyroid function tests are recommended where clinically indicated. In acromegalic patients and patients presenting with primitive thyrotropic adenoma, use of lanreotide is not exempt from the monitoring of the volume of the pituitary tumour. In patients without underlying cardiac problems, lanreotide may lead to a decrease of heart rate without necessarily reaching the threshold of bradycardia. In patients suffering from pre-existing cardiac disorders, sinus bradycardia may occur. Caution should be taken when initiating treatment with lanreotide in patients with bradycardia. The appearance of a significant and lasting increase of steatorrhoea justifies the complementary prescription of pancreatic extracts. **Pregnancy & Lactation:** Lanreotide should be administered to pregnant women only if clearly needed. Caution should be exercised when lanreotide is administered during lactation. Reduced fertility was observed in female rats. **Ability to Drive & Use Machines:** Dizziness, the patient should not drive or operate machinery. **Undesirable Effects:** Gastrointestinal disorders (diarrhea and abdominal pain), cholelithiasis and injection site reactions (pain, nodule and induration).
Date of preparation: 11st Nov, 2021.

SOM-HK-000183 (Oct/2023)

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IPSEN Pharma (Hong Kong)
34/F, Tower One, Times Square, 1 Matheson Road, Causeway Bay, Hong Kong
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Somatuline® autogel®
lanreotide

Ozempic® is **#1 prescribed brand** in GLP-1RA class[7‖]

4.1 million patients on treatment with Ozempic® worldwide[7‖]

For your adult patients with T2D[1]

The Ozempic® Zone delivers 3 proven benefits

POWERFUL GLYCAEMIC CONTROL[1–3*]

Up to 80% achieved ADA target of HbA_{1c} <7% vs other diabetes treatments[1–3,6†]

PROVEN CV RISK REDUCTION[1,4‡]

26% RRR of MACE vs placebo (2.3% ARR at 109 weeks) in patients with T2D with existed CVD or with high CV risk[4]

COMPELLING WEIGHT LOSS[1,5§]

Greater weight reduction (vs dulaglutide) was seen as dosage increased, with a mean weight loss of up to -6.5 kg with Ozempic® 1 mg

Abbreviated prescribing information (Please consult the full prescribing information before prescribing)
Ozempic® (semaglutide). Ozempic® 0.25 mg solution for injection in pre-filled pen; Ozempic® 0.5 mg solution for injection in pre-filled pen; Ozempic® 1 mg solution for injection in pre-filled pen.
Presentation: Ozempic® 0.25 mg & 0.5 mg solution for injection: Each pre-filled pen contains 2 mg semaglutide in 1.5 ml solution. Ozempic® 1 mg solution for injection: One pre-filled pen contains 4 mg semaglutide in 3.0 ml solution. **Indications:** Ozempic® is indicated 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. Combination therapy: in addition to other medicinal products for the treatment of diabetes. For study results with respect to combinations, effects on glycaemic control and cardiovascular events, and the populations studied, see the full prescribing information. **Dosage and Administration:** The starting dose is 0.25 mg Ozempic® once weekly. After 4 weeks the dose should be increased to 0.5 mg once weekly. After at least 4 weeks with a dose of 0.5 mg once weekly, the dose can be increased to 1 mg once weekly to further improve glycaemic control. Ozempic® 0.25 mg is not a maintenance dose. Weekly doses higher than 1 mg are not recommended. Ozempic® is to be administered once weekly at any time of the day, with or without meals. Ozempic® is to be injected subcutaneously in the abdomen, thigh or upper arm. Ozempic® should not be administered intravenously or intramuscularly. When Ozempic® is added to existing metformin and/or thiazolidinedione therapy or to a sodium-glucose cotransporter 2 (SGLT2) inhibitor, the current dose of metformin and/or thiazolidinedione or SGLT2 inhibitor can be continued unchanged. When Ozempic® is added to existing therapy of sulfonylurea (SU) or insulin, a reduction in the dose of SU or insulin should be considered to reduce the risk of hypoglycaemia. **Elderly:** No dose adjustment is required. Therapeutic experience in patients age ≥75 is limited. **Renal impairment:** No dose adjustment is required for patients with mild, moderate or severe renal impairment. Experience in patients with severe renal impairment is limited. Not recommended for use in patients with end-stage renal disease. **Hepatic impairment:** No dose adjustment is required for patients with hepatic impairment. Experience in patients with severe hepatic impairment is limited. Caution should be exercised when treating these patients with Ozempic®. **Paediatric population:** No data are available. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions for use:** Ozempic® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis. Ozempic® is not a substitute for insulin. Diabetic ketoacidosis has been reported in insulin-dependent patients after rapid discontinuation or dose reduction of insulin when treatment with a GLP-1 receptor agonist is started. There is no experience in patients with congestive heart failure NYHA class IV and Ozempic® is therefore not recommended in these patients. Use of GLP-1 receptor agonists may be associated with gastrointestinal adverse reactions. This should be considered when treating patients with impaired renal function as nausea, vomiting, and diarrhoea may cause dehydration, which could cause a deterioration of renal function. Acute pancreatitis has been observed with the use of GLP-1 receptor agonists. Patients should be informed of the characteristic symptoms of acute pancreatitis. If pancreatitis is suspected, Ozempic® should be discontinued; if confirmed, Ozempic® should not be restarted. Caution should be exercised in patients with a history of pancreatitis. Patients treated with Ozempic® in combination with a SU or insulin may have an increased risk of hypoglycaemia. Consider reducing the dose of SU or insulin when initiating treatment with Ozempic®. In patients with diabetic retinopathy treated with insulin and Ozempic®, an increased risk of developing diabetic retinopathy complications has been observed. Caution should be exercised when using Ozempic® in patients with diabetic retinopathy treated with insulin. These patients should be monitored closely and treated according to clinical guidelines. Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy, but other mechanisms cannot be excluded. When Ozempic® is used in combination with a SU or insulin, patients should be advised to take precautions to avoid hypoglycaemia while driving and using machines. **Pregnancy and lactation:** Women of childbearing potential are recommended to use contraception when treated with Ozempic®. Ozempic® should not be used during pregnancy or breast-feeding. If a patient wishes to become pregnant, or pregnancy occurs during treatment, Ozempic® should be discontinued. Discontinue at least 2 months before a planned pregnancy. **Undesirable Effects:** Very common (≥1/10): Hypoglycaemia when used with insulin or sulfonylurea, nausea, diarrhoea; Common (≥1/100 to <1/10): Hypoglycaemia when used with other oral antidiabetics, decreased appetite, dizziness, diabetic retinopathy complications, vomiting, abdominal pain, abdominal distension, constipation, dyspepsia, gastritis, gastro-oesophageal reflux disease, eructation, flatulence, cholelithiasis, fatigue, increased lipase, increased amylase, weight decreased; Uncommon (≥1/1,000 to <1/100): Hypersensitivity, dysgeusia, increased heart rate, acute pancreatitis, injection site reactions; Rare (≥1/10,000 to <1/1,000): Anaphylactic reaction; Not known (cannot be estimated from available data): Angioedema Date of review: Jun 2023

The image shown is a model and not a real patient.
* Results apply to Ozempic® across SUSTAIN trials, which included placebo, sitagliptin, dulaglutide, exenatide ER, insulin glargine, canagliflozin and liraglutide.[1-3]
† In head-to-head studies vs dulaglutide, insulin glargine, sitagliptin, liraglutide and canagliflozin.[1-3]
‡ Results apply to Ozempic® 0.5 mg and 1 mg plus SOC vs placebo plus SOC in adults with T2D with existed CVD or with high CV risk.[4]
§ Ozempic® is not indicated for weight loss.[1]
‖ Based on volume sales data: IQVIA-MIDAS database MAT 09.2022.

References:
1. Ozempic® H ong Kong Prescribing Information (8-9514-05-001-2). **2.** Lingvay I, Catarig AM, Frías JP, et al. Efficacy and safety of once-weekly semaglutide versus daily canagliflozin as add-on to metformin in patients with type 2 diabetes (SUSTAIN 8): a double-blind, phase 3b, randomised controlled trial. Lancet Diabetes Endocrinol. 2019;7(11):834-844.doi:10.1016/S2213-8587(19)30311-0 **3.** Capehorn MS, Catarig AM, Furberg JK, et al. Efficacy and safety of once-weekly semaglutide 1.0 mg vs once-daily liraglutide 1.2 mg as add-on to 1-3 oral antidiabetic drugs in subjects with type 2 diabetes (SUSTAIN 10). Diabetes Metab. 2020;46(2):100-109. doi:10.1016/j.diabet.2019.101117 **4.** Marso SP, Bain SC, Consoli A, et al; SUSTAIN-6 Investigators. Semaglutide and cardiovascular outcomes in patients with type 2 diabetes. N Engl J Med. 2016;375(19):1834-1844, doi:10.1056/NEJMoa1607141 **5.** Pratley RE, Aroda VR, Lingvay I, et al; SUSTAIN 7 Investigators. Semaglutide versus dulaglutide once weekly in patients with type 2 diabetes (SUSTAIN 7): a randomised, open-label, phase 3b trial. Lancet Diabetes Endocrinol. 2018;6(4):275-286. doi:10.1016/S2213-8587(18)30024-X **6.** American Diabetes Association. Glycemic targets: Standards of medical care in diabetes—2022. Diabetes Care. 2022;45(suppl 1):S83-S96. doi:10.2337/dc22-S006 **7.** Data on file, IQVIA-MIDAS claim letter November 2022.

Further Information is available from
Novo Nordisk Hong Kong Ltd
Unit 923A-928, 9/F Trade Square, 681 Cheung Sha Wan Road, Kowloon, Hong Kong
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ONCE-WEEKLY OZEMPIC® semaglutide injection

OZE-D-20230702

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

Toujeo®

From the start, there to help[1]

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

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

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

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

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

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

MAT-HK-2200793-1.0- 08/2022

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NT-proBNP Assay

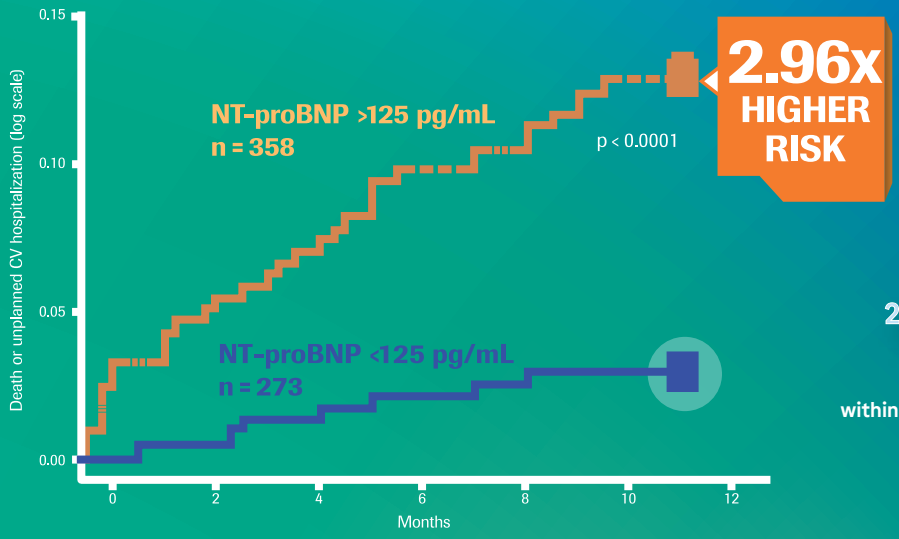
Identify high risk T2DM patients with the needs of cardioprotective treatment

125 pg/mL

A simple & clinically validated cut-off value[1-3]

- Provide clear indication of HF risk
- Support informed decision-making

Kaplan–Meier curves of all-cause mortality or unplanned CV hospitalization according to initial NT-proBNP concentration[1]



2.96 times more likely to experience unplanned hospitalization for CV events/death

within the next 12 months than patients with NT-probBNP <125 pg/mL[1]

Abbreviations: T2DM: type 2 diabetes mellitus; CV: cardiovascular; HF: heart failure.

References: 1. Huelsmann M, et al. Eur Heart J. 2008;29(18):2259-2264. doi:10.1093/eurheartj/ehn334; 2. Scirica, B.M. et al., Circulation, 2014; Vol. 130, pp. 1579 1588. 3. Roche Elecsys® Method sheet.

The cobas h 232 POC system

Support clinical decision-making at every stage of HF[4,5]

On-the-spot testing

- Immediately test for NT-proBNP[6]
- Result standardized with Roche central lab testing platform (Elecsys®)[7]
- Easy to use (No calibration/ Maintenance free)

References: 4. Ponikowski P, et al. European Journal of Heart Failure 2016;18:891-975; 5. Yancy CW, et al. Circulation 2017;136:e137-e161; 6. Roche (2016). cobas h 232 POC system Operator's Manual, Version 6.0; 7. Bertsch T, et al. Clin Lab 2010;56:37-49.

MAP-2023-JUN-001

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SURPRISINGLY CLEVER

A tighter target

The Accu-Chek Guide system exceeds industry standards with tighter accuracy[1]

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Strip removal is quick and clean

Clever SmartPack vial

Spill-resistant vial—easier to slide out one strip a time

Smartly stored data

Wirelessly sends results to the mySugr app

mySugr

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1. Brazg, R. L., Klaff, L. J. and Sussman, A. M. New Generation Blood Glucose Monitoring System Exceeds International Accuracy Standards. J Diabetes Sci Technol. 2016, 10(6): 1414-15

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DC-2021-AUG-005

forxiga
(dapagliflozin)

BRING PROTECTION TO LIFE IN CKD

THE ONLY SGLT2i

Now Approved for Chronic Kidney Disease Treatment*[1,2]

INITIATE TREATMENT[1,2]

GFR ≥25

ONCE DAILY tablet NO TITRATION[‡‡]

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

↓39% **Composite of CKD progression†, ESKD, and renal or CV death‡ vs placebo (NNT=19 patients)**
(HR 0.61; 95% CI, 0.51, 0.72; p<0.001)[3]

↓31% **All-cause mortality vs placebo**
(HR 0.69; 95% CI, 0.53, 0.88; p=0.004)[3]

↓29% **Composite of CV death or hHF vs placebo**
(HR 0.71; 95% CI, 0.55, 0.92; p=0.009)[3]

Slowed eGFR deterioration
(Between-group change/year in mean eGFR (chronic slope)):
1.9 mL/min/1.73 m² (FORXIGA/placebo)[3]

Consistent Efficacy§
Regardless of T2D status[3], baseline eGFR[4,7], CKD stage** and aetiology[3,7,8]

Simple and well tolerated
Consistent safety shown in patients with CKD, with or without T2D[3,7].
Similar hypoglycaemia rates¶ and less frequent AKI-related SAEs vs placebo[3,5]

* FORXIGA is indicated for the treatment of chronic kidney disease in adult patients with or without T2D.
† ≥50% sustained decline in eGFR.
‡ Three-item composite rates of the individual components of CV death or primary (2.0% vs 3.7%; HR 0.81; 95% CI, 0.68, 1.12).
§ Primary composite endpoint of ≥50% sustained decline in eGFR, reaching ESKD, and renal or CV death. ESKD is defined as the need for maintenance dialysis for at least 28 days and renal transplantation or sustained eGFR <15 mL/min/1.73m² for at least 28 days.
¶ Baseline eGFR categories: ≥45 mL/min/1.73m² and ≥45 mL/min/1.73m².
# Observed only in 120 patients.
** CKD stage groups: Stage 4 and Stage 3/3.
†† Diabetic nephropathy, glomerulonephritis, ischaemic or hypertensive CKD, or CKD of other or unknown cause.
‡‡ In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. If well tolerated, the dose may be increased to 10 mg.
§§ In TAFA-CKD, patients may continue on FORXIGA 10 mg once daily if eGFR falls below 25 mL/min/1.73m².
¶¶ Due to limited experience, it is not recommended to initiate treatment with dapagliflozin in patients with GFR <25 mL/min.

AKI, acute kidney injury; CI, confidence interval; CKD, chronic kidney disease; CV, cardiovascular; CVD, cardiovascular disease; eGFR, estimated glomerular filtration rate; ESKD, end-stage kidney disease; HF, heart failure; hHF, hospitalisation for heart failure; HR, hazard ratio; SAE, serious adverse event; SGLT2, sodium-glucose cotransporter-2 inhibitor; T2D, type 2 diabetes; UACR, urine albumin-creatinine ratio.

References: 1. FORXIGA Hong Kong Prescribing Information. 2. Heerspink HJL, et al. N Engl J Med. 2020;383:1436-1446. 3. Wheeler DC, et al. Lancet Diabetes Endocrinol. 2021;9:22-31. 4. Charytan DM, et al. J Am Soc Nephrol. 2021;32:2063-2361. 5. Heerspink HJL, et al. Kidney Int. 2021;100(6):1335[illegible]

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

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