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

EDM HK

28 – 29 October 2023 (Sat – Sun)

Navigating the New Normal

Programme Book
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**

**JARDIANCE demonstrated 38% RRR in CV death**

- Established HbA1c efficacy
- Demonstrated safety profile
- Convenient, once-daily oral dosing

**ADA & EASD** recognize JARDIANCE as the SGLT2 inhibitor with stronger evidence of CV benefits

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**CV cardiovascular, RRR relative risk reduction, ADA American Diabetes Association, EASD European Association for the Study of Diabetes, CV cardiovascular disease, SGLT2: sodium-glucose cotransporter 2, T2DM: type 2 diabetes mellitus**

**References:**

4. JARDIANCE demonstrated 38% in CV death in adult patients with inadequately controlled type 2 diabetes (HbA1c >7.5%) and established CV disease (coronary artery disease, peripheral artery disease, or a history of non-cardiac artery thrombosis).
5. Standard of care included CV medications and non-pharmacological agents as the discretion of the patient.
7. Prevalence of hyperglycemia in type 2 diabetes, 2019. A consensus report by the ADA and EASD stated that several patients with established CV disease have high cardiovascular risk, with the evidence of benefit medically stronger for empagliflozin than standard oral agents.

**JARDIANCE**

Empagliflozin is indicated in patients with type 2 diabetes and established CV disease to reduce the risk of cardiovascular death and hospitalization for heart failure. It should be used in addition to standard medical therapy for the treatment of established cardiovascular disease. The CV death and hospitalization risk is reduced in patients with type 2 diabetes who are at high risk for CV disease.

**THE ONLY DAD WITH CV INDICATION**

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

<table>
<thead>
<tr>
<th>Prof. Karen SL Lam</th>
<th>Prof. Kathryn CB Tan</th>
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<tr>
<td>Dr. YC Woo</td>
<td>Dr. TP Ip</td>
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<td>Dr. Paul CH Lee</td>
<td>Dr. Alan CH Lee</td>
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<td>Dr. David TW Lui</td>
<td>Dr. Eunice KH Leung</td>
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<td>Dr. Johnny YC Chang</td>
<td>Dr. Chariene SL Woo</td>
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<td>Dr. Lawrence CK Tang</td>
<td>Dr. KM Ma</td>
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<td>Ms. Karen KC Wong</td>
<td>Ms. SK Leung</td>
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<td>Ms. Connie HN Loong</td>
<td>Ms. Tina WT Lau</td>
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<td>Ms. Michelle HY Lee</td>
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## ACCREDITATIONS

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### CNE

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## SCIENTIFIC PROGRAMME
### 28 October 2023 (Saturday)

<table>
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<tr>
<th>Time</th>
<th>Room S221</th>
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<tbody>
<tr>
<td>13:00 – 13:35</td>
<td><strong>Lecture (1) (Sponsored by GlaxoSmithKline Limited)</strong></td>
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<tr>
<td></td>
<td>Chairperson: Dr. Cheung-hei Choi</td>
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<tr>
<td>13:00 – 13:35</td>
<td><strong>Herpes Zoster and Diabetes: Prevention and Clinical Management Strategies</strong></td>
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<td>Dr. Paul Lee (Hong Kong)</td>
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<tr>
<td>13:35 – 13:40</td>
<td>Q &amp; A</td>
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<tr>
<td>13:40 – 13:50</td>
<td><strong>Opening Ceremony</strong></td>
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<td><strong>Plenary Lecture (1)</strong></td>
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<td>Chairperson: Dr. John Ma</td>
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<tr>
<td>13:50 – 14:25</td>
<td><strong>Current Osteoporosis Guidelines: What Are Missing?</strong></td>
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<td>Dr. Tai-pang Ip (Hong Kong)</td>
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<tr>
<td>14:25 – 14:30</td>
<td>Q &amp; A</td>
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<td></td>
<td><strong>Symposium (1A)</strong></td>
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<td>Chairperson: Dr. Joanna Tung</td>
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<tr>
<td>14:30 – 14:55</td>
<td><strong>Navigating Life After Cancer – Endocrine Disorders in Survivors of Childhood Cancer</strong></td>
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<tr>
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<td>Dr. Sarah Poon (Hong Kong)</td>
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<tr>
<td>14:55 – 15:00</td>
<td><strong>Fertility Preservation: Where Are We Now?</strong></td>
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<td>Dr. Jennifer Ko (Hong Kong)</td>
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<tr>
<td>15:00 – 15:20</td>
<td><strong>Fertility Preservation: Where Are We Now?</strong></td>
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<td>Dr. Jennifer Ko (Hong Kong)</td>
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<td><strong>Fertility Preservation: Where Are We Now?</strong></td>
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<td>Dr. Jennifer Ko (Hong Kong)</td>
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<tr>
<td>15:20 – 15:30</td>
<td>Q &amp; A</td>
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<tr>
<td>15:30 – 16:00</td>
<td><strong>Coffee Break</strong></td>
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<tr>
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<td><strong>Symposium (1B)</strong></td>
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<td>Chairperson: Dr. Michele Yuen</td>
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<tr>
<td>16:00 – 16:35</td>
<td><strong>The Future of the Treatment of Diabetic Kidney Disease</strong></td>
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<tr>
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<td>Professor Hiddo Jan Lambers Heerspink (The Netherlands)</td>
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<tr>
<td>16:35 – 16:40</td>
<td>Q &amp; A</td>
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<tr>
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<td><strong>Lecture (2) (Sponsored by AstraZeneca Hong Kong Limited)</strong></td>
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<td>Chairperson: Dr. Annette Tso</td>
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<tr>
<td>16:40 – 17:15</td>
<td><strong>Interdisciplinary Management of Neuroendocrine Tumor</strong></td>
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<td>Dr. Roland Leung (Hong Kong)</td>
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<tr>
<td>17:15 – 17:20</td>
<td>Q &amp; A</td>
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<td><strong>EDM HK Cases of the Year</strong></td>
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<td>Chairperson: Dr. Alan Lee</td>
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<td>17:20 – 17:30</td>
<td><strong>A Lady Presented with Thyrotoxic Symptoms and Goitre but Normal TSH</strong></td>
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<td>Dr. Wai-sze Kwan (Hong Kong)</td>
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<td>17:30 – 17:40</td>
<td><strong>Breakdown of the Break Down Process – Urea Cycle Disorder</strong></td>
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<td>Dr. Chi-kin Ng (Hong Kong)</td>
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<td>17:40 – 17:50</td>
<td><strong>An Unexpected Adrenal Tumour in a Lady with Hypokalemic Hypertension</strong></td>
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<td>Dr. Yuk-kiu Fung (Hong Kong)</td>
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<td>17:50 – 18:00</td>
<td><strong>An Unfortunate Case of Pheochromocytoma Crisis</strong></td>
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<td>Dr. Chi-kin Tang (Hong Kong)</td>
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<td>09:30 – 10:05</td>
<td>Lecture (4) (Sponsored by Novo Nordisk Hong Kong Ltd.) Chairperson: Dr. Victor Hung</td>
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<td>Update of GLP-1RA in T2DM - Real World Evidence and CV Benefits</td>
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<td>Dr. Julie Lovshin (Canada)</td>
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<tr>
<td>10:05 – 10:10</td>
<td>Q &amp; A</td>
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<td>10:10 – 10:50</td>
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<tr>
<td>10:50 – 11:15</td>
<td>Symposium (2A) Chairperson: Dr. Doris Chan</td>
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<td>What’s New in Thyroid Eye Disease/Graves’ Orbitopathy</td>
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<td>Dr. Kelvin Chong (Hong Kong)</td>
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<td>11:15 – 11:40</td>
<td>Symposium (2B) Chairperson: Dr. YC Woo</td>
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<td>Glycemic Control in Pregnancy</td>
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<td>Dr. Risa Ozaki (Hong Kong)</td>
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<td>11:40 – 11:50</td>
<td>Q &amp; A</td>
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<tr>
<td>11:50 – 12:25</td>
<td>Plenary Lecture (2) Chairperson: Professor Karen Lam</td>
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<td>Aggressive Pituitary Tumours</td>
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<td>Dr. Ann McCormack (Australia)</td>
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<td>12:25 – 12:30</td>
<td>Q &amp; A</td>
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<td>13:00 – 13:40</td>
<td>Lecture (5) (Sponsored by Bayer HealthCare Limited) Chairperson: Dr. Vicki Tam</td>
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<td>New Insights of SGLT2 Inhibitor: How It Addresses Cardio-renal-metabolic Trio?</td>
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<td>Professor Dirk Müller-Wieland (Germany)</td>
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<td>13:40 – 13:45</td>
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<td>Lecture (6) (Sponsored by Eli Lilly Asia, Inc.) Chairperson: Dr. Chi-kin Yeung</td>
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<td>Incorporating Non-steroidal MRA into Clinical Practice for Diabetic Kidney Disease</td>
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<td>Dr. Desmond Yap (Hong Kong)</td>
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<td>14:20 – 14:25</td>
<td>Q &amp; A</td>
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<td>14:25 – 15:00</td>
<td>Lecture (7) (Sponsored by Sanofi Hong Kong Limited) Chairperson: Dr. Raymond Hue</td>
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<td>The Forgotten Incretin: Role of GIP in the Human Body and Type 2 Diabetes</td>
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<td>Dr. David Lui (Hong Kong)</td>
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<td>15:00 – 15:05</td>
<td>Q &amp; A</td>
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<td>Lecture (8) (Sponsored by Daiichi Sankyo Hong Kong Ltd.) Chairperson: Dr. Joanne Lam</td>
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<td>Concentrated Insulin, Angel or Devil?</td>
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<td>Dr. Matthew Tan (Singapore)</td>
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<td>16:10 – 16:15</td>
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<td>16:15 – 16:50</td>
<td>Meet the Expert Chairperson: Dr. Paul Lee</td>
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<td>Dr. Ann McCormack (Australia)</td>
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<td>Closing Remarks</td>
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LIST OF EXHIBITORS

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<td>ZP Therapeutics, Zuellig Pharma Limited</td>
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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
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Department</th>
<th>Hospital/Institution</th>
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<tbody>
<tr>
<td>Dr. Doris Chan</td>
<td>Consultant</td>
<td>Department of Medicine and Geriatrics</td>
<td>Pok Oi Hospital</td>
</tr>
<tr>
<td>Dr. Tai-pang Ip</td>
<td>Consultant</td>
<td>Department of Medicine</td>
<td>Tung Wah Hospital</td>
</tr>
<tr>
<td>Dr. Ka-fai Lee</td>
<td>Consultant</td>
<td>Department of Medicine and Geriatrics</td>
<td>Kwong Wah Hospital</td>
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<tr>
<td>Dr. Mandy Chan</td>
<td>Honorary Clinical Assistant Professor</td>
<td>Department of Medicine</td>
<td>The University of Hong Kong</td>
</tr>
<tr>
<td>Dr. Grace Kam</td>
<td>Consultant</td>
<td>Department of Medicine and Geriatrics</td>
<td>United Christian Hospital</td>
</tr>
<tr>
<td>Dr. Paul Lee</td>
<td>Clinical Assistant Professor</td>
<td>Department of Medicine</td>
<td>The University of Hong Kong</td>
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<tr>
<td>Dr. Nicole Chau</td>
<td>Associate Consultant</td>
<td>Department of Medicine and Geriatrics</td>
<td>Princess Margaret Hospital</td>
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<tr>
<td>Dr. Jennifer Ko</td>
<td>Consultant</td>
<td>Department of Obstetrics and Gynecology</td>
<td>Queen Mary Hospital</td>
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<tr>
<td>Dr. Roland Leung</td>
<td>Consultant</td>
<td>Department of Medicine</td>
<td>Queen Mary Hospital</td>
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<tr>
<td>Dr. Cheung-hei Choi</td>
<td>Consultant</td>
<td>Department of Medicine</td>
<td>Queen Elizabeth Hospital</td>
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<tr>
<td>Dr. Joanne Lam</td>
<td>Honorary Clinical Assistant Professor</td>
<td>Department of Medicine</td>
<td>The University of Hong Kong</td>
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<tr>
<td>Dr. David Lui</td>
<td>Clinical Assistant Professor</td>
<td>Department of Medicine</td>
<td>The University of Hong Kong</td>
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<tr>
<td>Dr. Kelvin Chong</td>
<td>Clinical Associate Professor</td>
<td>Department of Ophthalmology and Visual Sciences</td>
<td>The Chinese University of Hong Kong</td>
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<tr>
<td>Professor Karen Lam</td>
<td>Emeritus Professor of Medicine</td>
<td>Department of Medicine</td>
<td>The University of Hong Kong</td>
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<tr>
<td>Dr. John Ma</td>
<td>Specialty in Endocrinology, Diabetes and Metabolism</td>
<td>Private Practice</td>
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<tr>
<td>Dr. Raymond Hue</td>
<td>Associate Consultant</td>
<td>Department of Medicine</td>
<td>Pamela Youde Nethersole Eastern Hospital</td>
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<td>Professor Brian Lang</td>
<td>Li Shu Fan Medical Foundation Professor</td>
<td>Department of Surgery</td>
<td>The University of Hong Kong</td>
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<td>Dr. Jason Ng</td>
<td>Physician In-charge</td>
<td>Diabetes Centre</td>
<td>Queen Elizabeth Hospital</td>
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<td>Dr. Victor Hung</td>
<td>Consultant</td>
<td>Department of Medicine and Geriatrics</td>
<td>Princess Margaret Hospital</td>
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<td>Dr. Alan Lee</td>
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<td>Queen Mary Hospital</td>
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<tr>
<td>Dr. Risa Ozaki</td>
<td>Endocrine Division Head (Clinical Services)</td>
<td>Department of Medicine</td>
<td>Prince of Wales Hospital</td>
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LIST OF LOCAL FACULTY

Dr. Sarah Poon
Resident Specialist, Hong Kong Children’s Hospital

Dr. Joanna Tung
Consultant, Department of Paediatrics and Adolescent Medicine, Hong Kong Children’s Hospital

Dr. Desmond Yap
Clinical Associate Professor, Department of Medicine, The University of Hong Kong

Dr. Vicki Tam
Consultant, Department of Medicine and Geriatrics, Caritas Medical Centre

Dr. YC Woo
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Dr. Chi-kin Yeung
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Dr. Annette Tso
Specialty in Endocrinology, Diabetes and Metabolism, Private Practice

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

Dr. Michele Yuen
Honorary Clinical Assistant Professor, Department of Medicine, The University of Hong Kong
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.
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.
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.
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.
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.
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 glucany cyclase activators. The challenge for the future will be to tailor the optimal medication (or combination) to each patient.
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 with T2DM, 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.
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.
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.
Glycemic Control in Pregnancy

Dr. Risa Ozaki
Endocrine Division Head (Clinical Services)
Department of Medicine
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.
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)
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. 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.

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

Dr. Desmond Yap
Clinical Associate Professor
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.
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 1\(^{st}\) generation basal insulin analogs, insulin glargine 100 units/mL (Gla-100) and insulin detemir, and further into 2\(^{nd}\) generation basal insulin analogs (Gla-300 and insulin degludec)\(^1,2\).

By using a concentrated 2\(^{nd}\) generation basal insulin, such as Gla-300, patients could receive reduced injection volume compared to using Gla-100 when using the same injection unit\(^3\text{-}^5\). The injection depot size of Gla-300 is also reduced which allows an increase in the duration of action compared to Gla-100\(^3\text{-}^5\). 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 2\(^{nd}\) generation basal insulin. For Gla-300 and Gla-100, the starting dose is identical for insulin naïve 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 2\(^{nd}\) generation basal insulin, particularly focusing on Gla-300, switching from 1\(^{st}\) generation basal insulin to 2\(^{nd}\) generation basal insulin, the unmet need in the patients, and recent international diabetes recommendations.

Reference:
7. Toujeo Hong Kong prescribing information (approved by the Hong Kong Department of Health as of 16 Oct 2023)
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

Association of Hong Kong Diabetes Nurses

Hong Kong Obesity Society

The Hong Kong Society for Rehabilitation

The Hong Kong Society of Endocrinology, Metabolism and Reproduction

The Society of Hospital Pharmacists of Hong Kong

Youth Diabetes Action

Children’s Diabetes Association
For adult patients with CKD and T2D

A different pathway leads to different possibilities

Delay CKD progression with Kerendia

- The first and only non-steroidal MRA approved to treat CKD in T2D
- Proven to delay CKD progression and reduce the risk of CV events
- Manageable impact on serum potassium
- Included in 2022 ADA and KDIGO Guidelines with level A evidence

* 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.


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 laurylsulfate, talc, titanium dioxide, ferric oxide yellow (for 20 mg tablet), ferric oxide red (for 10 mg tablet). Indications: 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 <30 mL/min/1.73 m². The starting dose is: 20 mg once daily if eGFR ≥60 mL/min/1.73m² or 10 mg once daily if eGFR 22.5-59.9 mL/min/1.73 m². Continuation: Four weeks after initiation or re-start or sp. filtration, re-evaluate serum potassium and eGFR. Thereafter, re-evaluate serum potassium periodically and as needed based on patient characteristics and serum potassium levels. Contraindications: Taking concomitant medications that are strong CYP3A4 inhibitors. • Adrenal insufficiency. Warnings and precautions: • Hypokalemia. • 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/1.73 m². Continue Kerendia with caution regarding serum potassium levels in patients with end-stage renal disease (eGFR <15 mL/min/1.73 m²). 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 risks 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 (5-10%) hypoglycaemia, hypotension, glomerular filtration rate decreased. For further details, please refer to the full prescribing information (July 2022) (M/MC/FRS/HK-2014/4 Dec 2020).

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STRUGGLING TO CONTROL ELEVATED LDL-C?

When you and your patients are fighting to take back cholesterol control, add on oral, once daily

NILEMDO® (bempedoic acid)

NUSTENDI® (bempedoic acid and ezetimibe)

LDL-C: low-density lipoprotein cholesterol.

References:

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. May increase blood 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 signs 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 extremities, anemia, and elevated liver enzymes. Others: tendon rupture, neuritis, benign prostatic hypertrophy, 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. 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 extremities, anemia, elevated liver enzymes, and elevated liver enzymes. Others: tendon rupture, pain in extremity, anemia, elevated liver enzymes, and elevated liver enzymes. Others: tendon rupture, neuritis, benign prostatic hypertrophy, 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. Version: Mar 2023.


About Daiichi-Sankyo
Daiichi Sankyo Hong Kong Limited
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HK-DAI-NN-2307005
Date of Approval: Jul 2023

The materials for Nilemdo® (Bempedoic acid) and Nustendi® (Bempedoic acid and ezetimibe) contained in this virtual exhibition are approved for use only in Hong Kong. Package insert may vary depending on local approval in each country. Therefore, before prescribing any product, always refer to local materials such as the package insert and/or the Summary of Product Characteristics (SPC).
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

Therefore, before prescribing any product, always refer to local materials such as the package insert and/or the Summary of Product Characteristics (SPC).

LDL-C: low density lipoprotein cholesterol.

Ballantyne CM et al. 2019; 8:e011662.
Ballantyne CM et al. 2018; 277: 195-203.

References:

‡ vs placebo on top of maximally tolerated statins. 7
† 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 intensity statins. 3

* Avoid concomitant use of Nilemdo ® /Nustendi ® with simvastatin >20 mg, or with pravastatin >40 mg. 1,2

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:

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.

Drug Interactions:

Simvastatin:

Avoid concomitant use of Nilemdo with simvastatin greater than 20 mg.

Pravastatin:

Avoid concomitant use of Nustendi with pravastatin.

Fibrates:

If cholelithiasis is suspected in a patient receiving Nustendi and fenofibrate, consider alternative lipid-lowering therapy.

Cyclosporine:

Monitor cyclosporine concentrations.

Others include tendon rupture, gout, benign prostatic hyperplasia, atrial fibrillation.

Warnings and Precautions:

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.

Indications:

Administer 180 mg orally once daily with or without food.

Dosage and Administration:

None.

Contraindications:

Known hypersensitivity to ezetimibe tablets.

Nilemdo Hong Kong Package Insert Mar 2023.
Nustendi Hong Kong Package Insert Mar 2023.
SHINGRIX
(ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

A NEW GENERATION OF HERPES ZOSTER VACCINE

PREVENT SHINGLES
DON'T GIVE IT A CHANCE

THE US CDC Recommends SHINGRIX As The Preferred Vaccine For The Prevention Of SHINGLES

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, malaise, fatigue and headache. Most of these reactions were not long-lasting. In adults 18 years or above who are immunocompromised or immuno-suppressed 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 16-49 years at increased risk of HZ who are not IC.

Abbreviated Prescribing Information

Name of the manufacturer: GlaxoSmithKline Biologicals (S.A.A.) in the European Union; Sankyo Co., Ltd and GlaxoSmithKline Biologicals in Japan; GlaxoSmithKline Biologicals (Mérieux Vaccins SA) in Switzerland; GlaxoSmithKline Biologicals (Pty) Ltd in South Africa. GlaxoSmithKline Biologicals (Pty) Ltd is the holding company for GlaxoSmithKline Biologicals South Africa (Pty) Ltd, which is the producer of the vaccine in South Africa.

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. The primary vaccination schedule consists of 2 doses of Shingrix administered 2 months apart. An additional dose is recommended in adults 70 years of age or older. Shingrix is not recommended for use in individuals who are immunocompromised due to disease or therapy (referred to as immunocompromised 21). Shingrix is contraindicated for immunocompromised (IC) individuals aged ≤50 years. Shingrix is not recommended for use in individuals with a history of severe allergic reaction (anaphylactic) to any component of Shingrix. Shingrix is not recommended for administration to individuals who have been immunized with a previous dose of Shingrix.

Precautions: Shingrix should be administered to individuals who are at increased risk of developing HZ. Shingrix is not recommended for use in individuals with a history of severe allergic reaction (anaphylactic) to any component of Shingrix. Shingrix is not recommended for administration to individuals who have been immunized with a previous dose of Shingrix.

Warnings: Shingrix should be administered to individuals who are at increased risk of developing HZ. Shingrix is not recommended for use in individuals with a history of severe allergic reaction (anaphylactic) to any component of Shingrix. Shingrix is not recommended for administration to individuals who have been immunized with a previous dose of Shingrix.

Adverse reactions: Shingrix is generally well tolerated. The most common adverse reactions are pain at the injection site, malaise, fatigue and headache. Most of these reactions were not long-lasting. In adults 18 years or above who are immunocompromised or immuno-suppressed 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 16-49 years at increased risk of HZ who are not IC.

The only RVV with over 90% vaccine efficacy.

References:


GSK

Discover the power of SHINGRIX at gskpro.com/en-hk
**Since when did medicine ever settle for the status quo?**

**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

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1. Abbreviations: SC, subcutaneous; SSA, somatostatin analogue


Somatuline® Autogel® Prescribing Information

Trade Name: Somatuline® Autogel 60, 120 mg prolonged-release solution for injection in a pre-filled syringe.

**Dosage & Administration:** The solution should be injected via the deep subcutaneous route in the superior external quadrant of the buttock. The duration of administration by the patient or another trusted person should be taken by the healthcare professional. The recommended dose is 60 mg every 24 days. Carcinoid tumor: the recommended starting dose is 60 mg every 24 days, which may be adjusted to a maximum of 70 mg every 24 days.

**Contraindications:** Somatuline® Autogel is contraindicated in patients with a history of severe sulfa allergy.

**Warnings & Precautions:** Somatuline® Autogel may reduce the risk of bowel obstruction in patients with carcinoid tumor.

**Adverse Effects:** Somatuline® Autogel may cause the following adverse effects: pain at injection site, diarrhea, nausea, vomiting, metallic taste, increased abdominal pain, headache, skin reactions, allergic reactions, flu-like syndrome, hypokalemia, electrolyte imbalance, proteinuria, and decreased sweating.

**Interactions:** Somatuline® Autogel may interact with other drugs, including sulfa antibiotics, carbamazepine, and valproic acid.

**Pregnancy & Lactation:** Somatuline® Autogel is not recommended for use during pregnancy or lactation.

**Safety & Security:** Somatuline® Autogel should be stored at room temperature (15-30°C) and protected from light.

**Dose & Administration:** Somatuline® Autogel is administered to patients with carcinoid tumor via a subcutaneous injection. The recommended dose is 60 mg every 24 days. The injection site should be changed every 24 days to minimize the risk of localized toxicity.

**Ability to Drive & Use Machinery:** Somatuline® Autogel may cause dizziness and drowsiness, so patients should avoid driving or operating machinery.

**Date of preparation:** 11th Nov 2021.
The Ozempic® Zone delivers 3 proven benefits

POWERFUL GLYCAEMIC CONTROL

Up to 80% achieved ADA target of HbA1c <7% vs other diabetes treatments

PROVEN CV RISK REDUCTION

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

COMPELLING WEIGHT LOSS

Greater weight reduction (vs dulaglutide) was seen as dosage increased, with a mean weight loss of up to 4.5 kg with Ozempic® 1 mg
From the start, there to help

- Help your patients find balance between HbA1c reduction and hypoglycemic risk.\footnote{1}
- With a more stable 24-hour glycemic profile.\footnote{1,8}
- In a convenient\footnote{1} insulin experience.\footnote{1,9,10}

Help your patients get the start they deserve

\footnote{1}{In steady-state PK/PD analyses in T2DM, Toujeo® showed a more stable and prolonged glucose lowering effect compared to insulin glargine 100 units/mL.\footnote{1,2}}

\footnote{1,2}{Toujeo® is available in easy-to-use pens.\footnote{1,2} To be administered once daily at any time of the day preferably at the same time every day. 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.\footnote{1,2}}


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. If 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 occur. 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 glucoseogenesis and reduced insulin metabolism. Perform continuous injection of injection site to reduce risk of hypoglycaemia and cutaneous amyloidosis. Blood glucose monitoring is recommended after change in injection site. Hypoglycaemia, Intermittent illness. Combination of Toujeo with pegvisomant. Medication errors prevention. Interactions: Effects enhanced by oral antidiabetics, ACE inhibitors, fibrates, flutamide, MAOIs, pentoxyfilline, propoxyphene, salicylates, sulfonamide antibiotics. Effects reduced by corticosteroids, danazol, diazoxide, diuretics, glucagon, isoniazid, oestrogens and prostaglandins, phenothiazine derivatives, somatropin, sympathomimetics, or thyroid hormones, atypical antipsychotics and protease inhibitors. Beta-blockers, clindamycin, Etoricoxib or alcohol may either potentiate or weaken the effects of insulin. Pentamidine may cause hypoglycaemia, followed by hypoglycaemia. The signs of adrenal counter-regulation may be reduced or absent under the influence of sympatholytic medicinal products such as beta-blockers, clindamycin, 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, secure 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. Preparation: Toujeo 6 x 30 ml (1800 IU) pre-filled pens. Legal classification: Part 1 Poison Full prescribing information is available upon request. AP-HK-TOU-20,09
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Ultra Plus Flex®
穩豪智優型血糖機

顏色指示功能

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新新一代金屬基試紙，減少干擾
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藍芽傳輸測試結果

兼容「智抗糖」行動應用程式，
儲存和追跡測試結果無難度

符合國際標準 EN ISO15197:2015

免調碼 5秒測試

個人化血糖範圍限制值

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.ONE TOUCH® 客戶服務熱線 +85227358262
NT-proBNP Assay

Identify high risk T2DM patients with the needs of cardioprotective treatment

125 pg/mL

A simple & clinically validated cut-off value

- 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

2.96 times more likely to experience unplanned hospitalization for CV events/death within the next 12 months than patients with NT-proBNP <125 pg/mL

The cobas h 232 POC system

Support clinical decision-making at every stage of HF

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

References:
A tighter target
The Accu-Chek Guide system exceeds industry standards with tighter accuracy.

Strip ejector button
Strip removal is quick and clean

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

Smartly stored data
Wirelessly sends results to the mySugr app
BRING PROTECTION TO LIFE IN CKD

THE ONLY SGLT2i

New Approved for Chronic Kidney Disease Treatment*1,11

Composite of CKD progression¹, ESKD, and renal or CV death² vs placebo (NNT=19 patients)

\[ HR \text{ 0.61; 95\% CI, 0.51, 0.72; p<0.001} \]

All-cause mortality vs placebo

\[ HR \text{ 0.61; 95\% CI, 0.53, 0.68; p<0.004} \]

Composite of CV death or hHF vs placebo

\[ HR \text{ 0.71; 95\% CI, 0.55, 0.92; p=0.009} \]

Slowed eGFR deterioration

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

Consistent Efficacy³

Regardless of T2D status¹, baseline eGFR³, CKD stage⁴, and aetiology⁴,⁵,⁶

Simple and well tolerated

Consistent safety shown in patients with CKD, with or without T2D³,
Similar hypoglycaemia rates³ and less frequent AEs vs placebo³,³

For broad range¹¹ of CKD patients, TREAT EARLY WITH FORXIGA NOW

REFERENCES

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