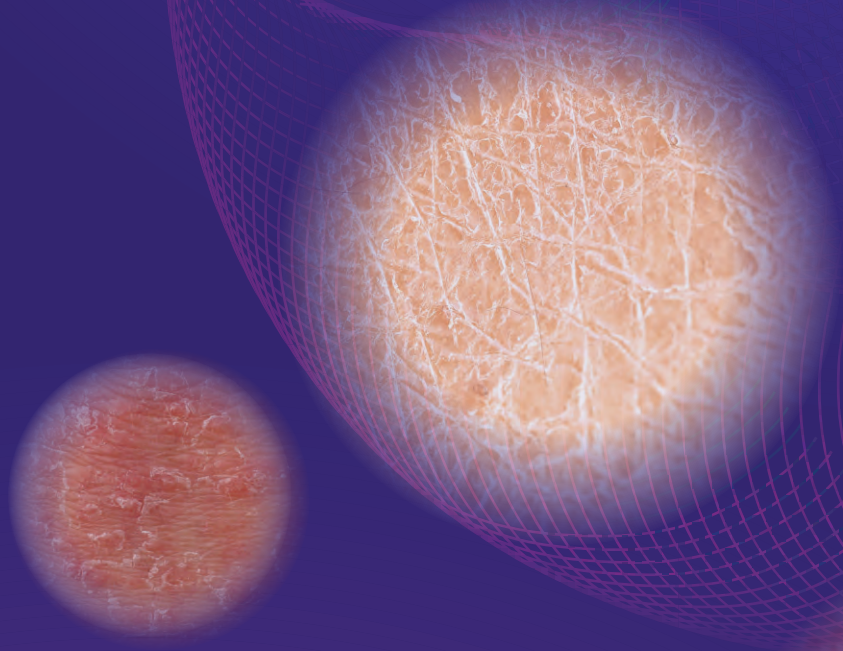
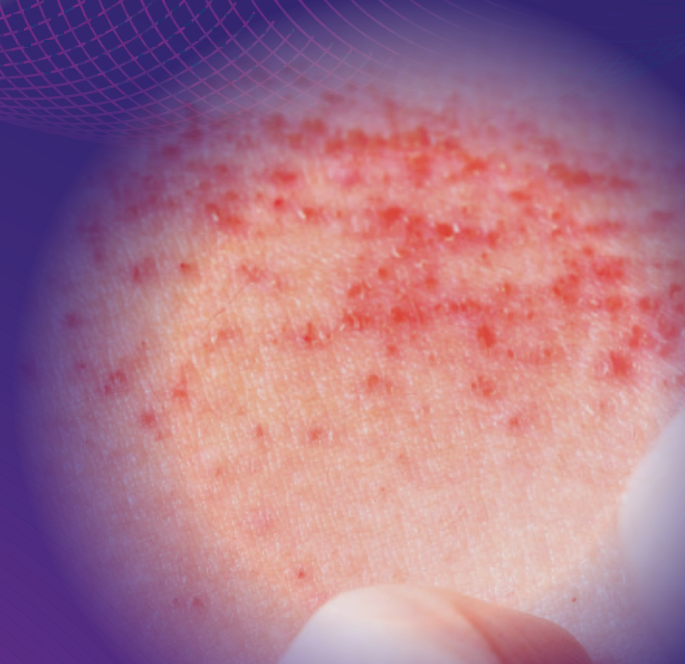
HKCD and HKSPD

JOINT ANNUAL SCIENTIFIC MEETING 2020

6 December 2020 • Sunday





Organizers:

HKCD
HONG KONG COLLEGE OF DERMATOLOGISTS
香港皮膚科醫學院

HKSPD
THE HONG KONG SOCIETY FOR PAEDIATRIC DERMATOLOGY

SHARED RESULTS

SHARED RELIEF

NOW APPROVED FOR PATIENTS WITH MODERATE-TO-SEVERE ATOPIC DERMATITIS AGED 12-17[1]

- First and only therapy that **specifically targets IL-4 and IL-13,** key drivers of persistent underlying Type 2 inflammation[1,2]
- **Rapid improvement** in lesion extent and severity, pruritus intensity and quality-of-life measures[1,3]
- Demonstrated a **consistent safety profile** in adults and adolescents[1]
  - No monitoring for organ toxicities required[1]
  - Most common adverse reactions were injection site reactions, conjunctivitis, blepharitis, and oral herpes[1]

Study Design[3]: A randomised, double-blind, parallel-group, phase 3 clinical trial conducted at 45 US and Canadian centres between March 21, 2017, and June 5, 2018. A total of 251 adolescents with moderate to severe AD inadequately controlled by topical medications or for whom topical therapy was inadvisable were included. Patients were randomised (1:1:1; interactive-response system; stratified by severity and body weight) to 16-week treatment with DUPIXENT®, 200 mg (n = 43; baseline weight <60 kg), or DUPIXENT®, 300 mg (n = 39; baseline weight ≥60 kg), every 2 weeks; DUPIXENT®, 300 mg, every 4 weeks (n = 84); or placebo (n = 85). Main outcomes were proportion of patients with 75% or more improvement from baseline in Eczema Area and Severity Index (EASI-75) (scores range from 0 to 72, with higher scores indicating greater severity) and Investigator's Global Assessment (IGA) 0 or 1 on a 5-point scale (scores range from 0 to 4, with higher scores indicating greater severity) at week 16.

DUPIXENT® is indicated for the treatment of moderate-to-severe atopic dermatitis in patients aged 12 years or older who are candidates for systemic therapy.

References: 1. DUPIXENT® Hong Kong Prescribing Information. **2.** Gandhi NA et al. Nature Rev Drug Disc 2016; 15: 35–50. **3.** Simpson EL, Paller AS, Siegfried EC, et al. JAMA Dermatol 2019;156:44–56.

Presentation: Dupilumab solution for injection in a pre-filled syringe with needle shield. **Indications:** Atopic Dermatitis (AD): Moderate-to-severe AD in adults and adolescents ≥12 years who are candidates for systemic therapy. Asthma: In adults and adolescents ≥12 years as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. AD adolescents: Body weight <60 kg- initial dose of 400 mg (two 200mg injections), followed by 200 mg every other week. Body weight ≥60 kg- same dosage as adults. Dupilumab can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, e.g. face, neck, intertriginous and genital areas. Consider discontinuing treatment in patients who have shown no response after 16 weeks. Asthma: Initial dose of 400 mg, followed by 200 mg every other week. For patients with severe asthma and on oral corticosteroids or with severe asthma and co-morbid moderate-to-severe AD- initial dose of 600 mg, followed by 300 mg every other week. Patients receiving concomitant oral corticosteroids may reduce steroid dose gradually once clinical improvement with dupilumab has occurred. The need for continued dupilumab therapy should be considered at least annually as determined by a physician. If a dose is missed, administer it asap and thereafter, resume dosing at the regular scheduled time. **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Safety and efficacy in children <12 years not been established. Not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm or status asthmaticus. Do not discontinue corticosteroids abruptly upon start of dupilumab. Reduction should be gradual and performed under supervision of a physician; it may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy. Biomarkers of type 2 inflammation may be suppressed by systemic corticosteroid use. If systemic hypersensitivity reaction occurs, discontinue dupilumab and initiate appropriate therapy. Be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in patients with eosinophilia. Treat pre-existing helminth infections before initiating dupilumab. If patients become infected while receiving dupilumab and do not respond to anti-helminth treatment, discontinue dupilumab until infection resolves. Patients who develop conjunctivitis that does not resolve following standard treatment should undergo ophthalmological examination. AD patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Do not give live and live attenuated vaccines concurrently with dupilumab. Patients should be brought up to date with immunisations before starting dupilumab. **Drug Interactions:** Immune responses to TdaP vaccine and meningococcal polysaccharide vaccine were assessed. Patients receiving dupilumab may receive concurrent inactivated or non-live vaccinations. **Pregnancy and lactation:** Should be used during pregnancy only if potential benefit justifies potential risk to foetus. Unknown whether dupilumab is excreted in human milk or absorbed systemically after ingestion. Decision must be made whether to discontinue breast-feeding or dupilumab taking into account benefit of breast feeding for the child and benefit of therapy for the woman. **Undesirable effects:** AD: Most common adverse reactions reported- injection site reactions, conjunctivitis, blepharitis and oral herpes. Safety profile observed in adolescents consistent with that seen in adults. Asthma: Most common adverse reaction reported- injection site erythema. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 2 x 300mg/2ml in pre-filled syringe with needle shield, 2 x 200mg/1.14ml in pre-filled syringe with needle shield. **Legal Classification:** Part 1, First & Third Schedules Poison **Full prescribing information is available upon request.** API-HK-DUP-20.05

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Welcome Message

Dear Colleagues,

I look forward to welcoming you to the first ever virtual joint annual scientific meeting with the Hong Kong Society for Paediatric Dermatology. COVID-19 has wreaked havoc to our daily social and professional lives and there is no end in sight yet. During these difficult times, we are really lucky that modern technology has come to our rescue.

This year in addition to our usual 3 symposia, we have a "State-of-the-Art Lecture" by Dr. Chih-ho HONG of Canada immediately following our AGMs.

Atopic dermatitis and psoriasis continue to occupy a significant part in our daily dermatological practice. New forms of therapy are being introduced so fast that some of us may find it hard to keep up with. Thus 2 symposia are devoted to these topics.

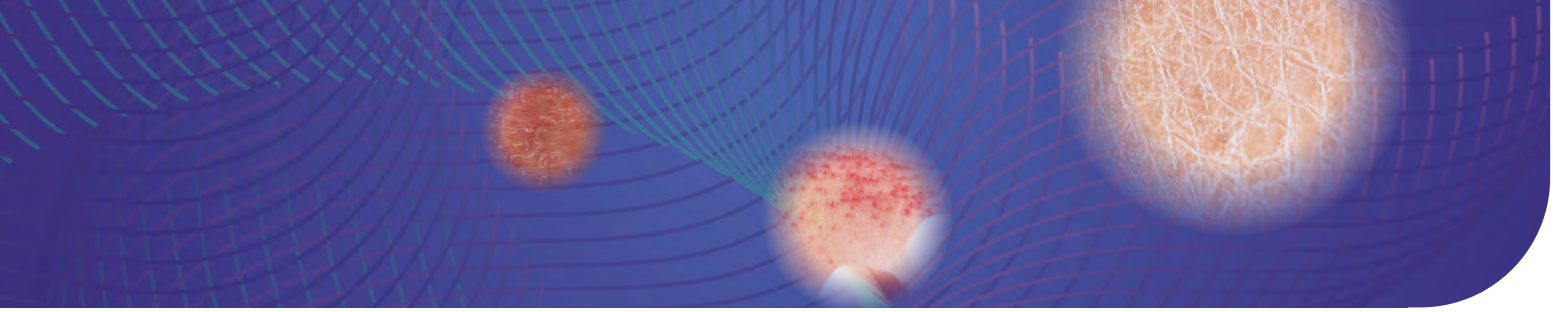
A third symposium will focus on "interesting cases" to be presented by our local colleagues. This is the first time that a whole session is allotted on it.

As usual, I wish to thank all the participants and sponsors for their continuous and generous support.

Dr. Sze-kee LEUNG

President

Hong Kong College of Dermatologists



Dear Friends and Colleagues,

On behalf of the Council of the Hong Kong Society for Paediatric Dermatology (HKSPD), I warmly welcome you to our Annual Scientific Meeting 2020, which is jointly organized by the HKSPD and the Hong Kong College of Dermatologists.

Over the years, the meeting has been providing a platform for dermatologists, paediatricians and general practitioners to share their experience, expertise, and perspectives. It is also a platform for professional networking and collaboration in the rapidly evolving field.

With the on-going COVID-19 pandemic, various aspects of our health-care system and clinical practices have been impacted. With the advancement of novel therapeutic options in atopic dermatitis and psoriasis, we have more choices to manage these conditions safely and effectively in all age groups. We are happy to introduce a clinical-pathologic correlation session for discussion of interesting cases encountered in public and private settings.

Lastly, I would like to express my heartfelt gratitude to our distinguished speakers, council members, sponsors and participants for the continued support. I hope you will enjoy the virtual meeting!

Dr. Mimi CHANG

Chairman

The Hong Kong Society for Paediatric Dermatology

Council of Hong Kong College of Dermatologists

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Vice-Presidents:	Dr. Cham-fai LAI Dr. Kuen-kong LO
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Honorary Secretary:	Dr. King-man HO
Honorary Treasurer:	Dr. Fong-cheng IP
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Academic Accreditations

Organization	Points Accredited
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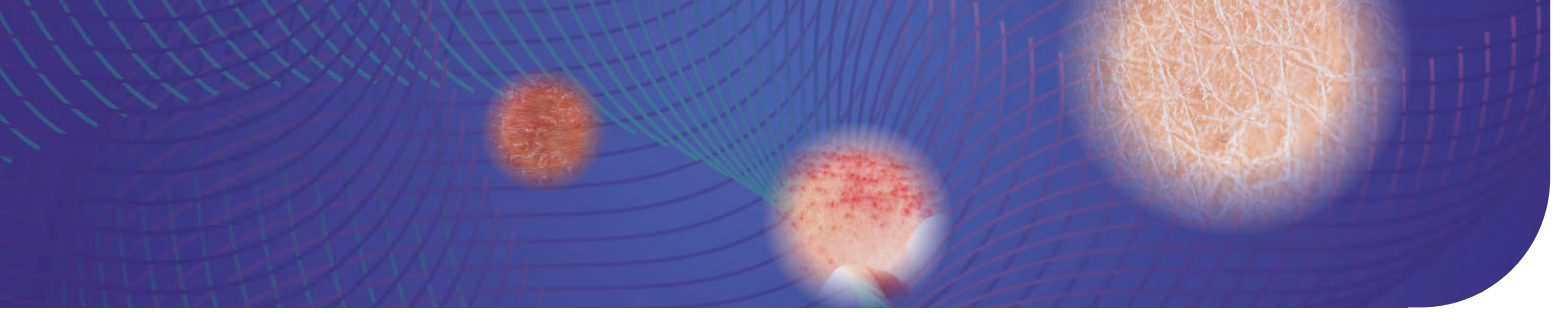
The Hong Kong College of Family Physicians	3
Hong Kong College of Paediatricians	4
The Hong Kong College of Pathologists	4
Hong Kong College of Physicians	4
The College of Surgeons of Hong Kong	4.5
MCHK Programme	4



Faculty Members

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Honorary Clinical Assistant Professor, Division of Dermatology, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Yung CHAN
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

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Senior Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

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Programme

10:15 – 10:25	Welcome Remarks by Chairmen of HKCD & HKSPD
10:25 – 11:15	**Symposium I: Advances in the Usage of Biologics in Dermatology** Chairmen: Dr. William FUNG & Dr. Cham-fai LAI A New Era in the Treatment of Atopic Dermatitis Dr. Yung CHAN (Hong Kong) Immunogenicity of Biologics from an Immunologist's Perspective Dr. Philip LI (Hong Kong) Q&A
11:15 – 11:30	Break
11:30 – 12:45	**Symposium II: Advances in the Treatment of Psoriasis** Chairmen: Dr. Fong-cheng IP & Dr. Sze-kee LEUNG Psoriasis as a Systemic Inflammatory Disease: The Role of IL-23/Th17 Immune Axis in the Pathogenesis of Psoriasis and Comorbidities Prof. Henry CHAN (Hong Kong) Achieving Sustainable PASI100 - The New Normal Dr. Johnny CHAN (Hong Kong) The Importance of Achieving Complete Skin Clearance That Lasts and the Implications of Rapid Onset for Patient Treatment Satisfaction Dr. Piergiorgio MALAGOLI (Italy) Q&A
12:45 – 14:00	Lunch Break
12:50 – 13:20	AGMs
14:00 – 14:45	**State-of-the-Art Lecture (sponsored by Sanofi Hong Kong Limited)** Chairman: Dr. Chi-keung YEUNG The Game Changer for Moderate-to-Severe Atopic Dermatitis in Adolescents Dr. Chih-ho HONG (Canada) Q&A
14:45 – 15:00	Break
15:00 – 16:15	**Symposium III: Interesting Cases Sharing** Chairmen: Dr. Mimi CHANG & Dr. Kuen-kong LO Scalp Biopsy in Alopecia Dr. Paul CHOI (Hong Kong) & Dr. Mimi CHANG (Hong Kong) Pyoderma Gangrenosum or Necrotizing Fasciitis: A Case of Limb Salvaging Experience and a Case Series in a Tertiary Hospital, Hong Kong Dr. Christina WONG (Hong Kong) Erythroderma in a Patient with Thymoma and Severe Pneumonia Dr. William NGAN (Hong Kong) Q&A

Symposium I: Advances in the Usage of Biologics in Dermatology

A New Era in the Treatment of Atopic Dermatitis

Dr. Yung CHAN
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

Dr. Yung CHAN is a private practicing specialist in dermatology. He is the honorary consultant at Matilda International Hospital. Upon his graduation from the University in Hong Kong, he underwent dermatology specialist training in Social Hygiene service in the Department of Health and was accredited for specialist in dermatology in 2014. He is a member of the Hong Kong Journal of Dermatology and Venerology editorial board and has published number of peer-reviewed articles in internationally indexed and local journals. He has also been an active speaker for both local and international meetings and symposiums. His major research interests include inflammatory dermatoses, dermatologic surgery and cosmetic dermatology.

ABSTRACT

Atopic dermatitis (AD) is a chronic relapsing skin inflammatory disorder commonly causing troublesome symptoms such as itchiness of skin. AD causes significant burden on both physical and psychological aspects of patients and may adversely impact the quality of life of patients.

Despite the availability of treatment, unmet needs are identified from the conventional treatments. Topical corticosteroids may give rise to undesirable events including skin atrophy and poor drug compliance arising from steroid phobia. Topical calcineurin inhibitors are steroid-free alternatives but they are frequently associated with application site pain which may not be favorable for patients.

Crisaborole is a first-in-class, non-steroidal topical therapy that inhibits the phosphodiesterase (PDE)-4 enzyme in the skin. Its efficacy and safety were well demonstrated through randomised controlled phase 3 trials and currently it was approved by the US FDA for treating mild-to-moderate AD. The introduction of crisaborole offers clinicians a novel option in the decision of treatment of mild-to-moderate AD. This lecture will discuss how crisaborole addresses current unmet needs in the AD treatment paradigm as a novel treatment, with a summary of the efficacy and safety data of crisaborole. Patient cases will be shared to provide clinicians with more insights on the choice of potential patients for the treatment and the efficacy of crisaborole in real world settings.

Symposium I: Advances in the Usage of Biologics in Dermatology

Immunogenicity of Biologics from an Immunologist's Perspective

Dr. Philip LI
Clinical Assistant Professor, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Philip LI is a Specialist in Immunology & Allergy and Clinical Assistant Professor under the Department of Medicine at the University of Hong Kong. He graduated with his MBBS and Master of Research in Medicine at the University of Hong Kong in 2012, and joined the Department of Medicine of Queen Mary Hospital in 2013. He underwent overseas training at the Department of Allergy at Guy's and St Thomas' Hospital, as well as the Departments of Immunology at the Royal Free Hospital and Royal London Hospital in London. Dr LI completed his specialist training in Immunology & Allergy and was conferred Fellow of the Hong Kong College of Physicians and Hong Kong Academy of Medicine in 2019.

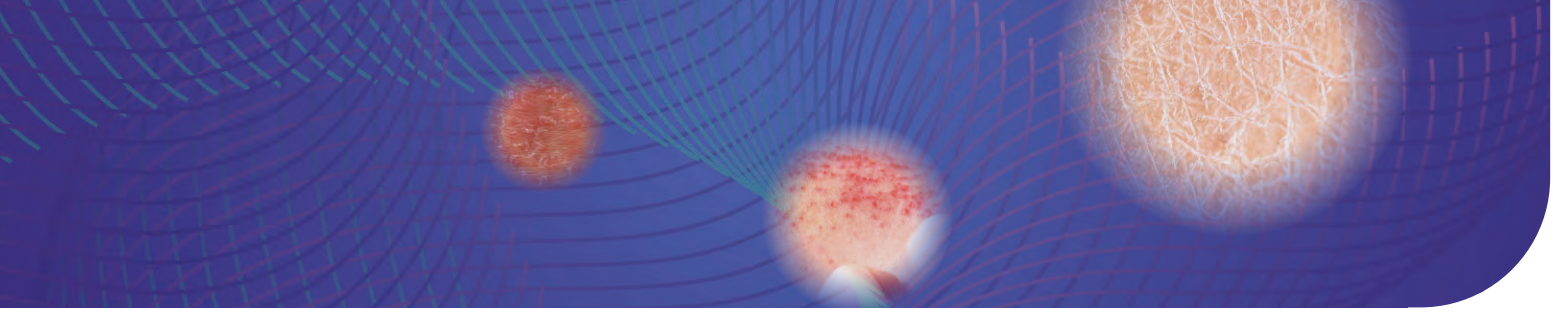
Dr. LI has led the development of the in-patient drug allergy and immunology service as well as establishing the Immunology Clinics at Queen Mary and Grantham Hospitals. Since then, he has diagnosed many "first" adult immunodeficiency syndromes in Hong Kong and rare causes of previously undiagnosed anaphylaxis. Dr. LI is also an executive committee member of the Hong Kong Allergy Association, member of the Asia Pacific Association of Allergy Asthma and Clinical Immunology's Drug Allergy Committee and helped to establish Hong Kong's Hereditary Angioedema patient support group.

Dr. LI has special interests in anaphylaxis, drug hypersensitivity and immunodeficiency. He conducted the region's foremost drug allergy studies which paved the way toward Hong Kong's drug allergy de-labelling initiative. He has published over 50 peer-reviewed articles in the fields of allergy, immunology and autoimmunity. Dr. LI authored the first Immunology & Allergy chapter of the Hospital Authority's Handbook of Internal Medicine in 2019. He also led and authored the territory's first consensus statements on anaphylaxis on behalf of the Hong Kong Anaphylaxis Consortium.

ABSTRACT

Since the advent of the first therapeutic monoclonal antibody more than 30 years ago, biological agents have played a significant impact on the management of different diseases. Unlike traditional small molecular drugs, biologics are recognized as "non-self" by the host and generates immune response an ("immunogenicity"). This occurs in all patients exposed to biologics with variable degree of clinical consequence, depending on a range of drug- or patient-specific factors.

The immunogenicity potential of biologics is of particular interest for physicians especially as it can lead to numerous unwanted and devastating consequences. For example, the formation of anti-drug antibodies can result in infusion/hypersensitivity reactions, neutralization of intended biologic effects as well as affect drug bioavailability and clearance. However, presence of anti-drug antibodies may also be of no clinical consequence, which makes interpretation difficult. The field of immunogenicity and ADA is ever-expanding, and an inter-disciplinary approach is now needed more than ever. In this session, clinical examples and review of the clinical implications of immunogenicity relevant for the practicing physician will be discussed.



Symposium II: Advances in the Treatment of Psoriasis

Psoriasis as a Systemic Inflammatory Disease: The Role of IL-23/Th17 Immune Axis in the Pathogenesis of Psoriasis and Comorbidities

Professor Henry CHAN

Honorary Clinical Professor and Honorary Consultant Dermatologist, Division of Dermatology, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Henry CHAN is a specialist in dermatology. He is also currently the Honorary Clinical Professor and Honorary Consultant Dermatologist of the Division of Dermatology, Department of Medicine, The University of Hong Kong, Queen Mary Hospital, Hong Kong and Visiting Scientist (research staff) of the Wellman Center for Photomedicine, Massachusetts General Hospital, Boston, USA. He is council and court member of the University of Hong Kong.

Dr. CHAN's work in Boston has led him to hold five patents published by the World Intellectual property organization (WO 2013/075006 A1 and WO 2013/075016 A1 and WO 2015/021462 A1 and WO 2015/123420 A1 and WO 2018/119453 A1). In 2011, he and 3 other colleagues (Dr Rox Anderson, Dr Dieter Manstein and Dr Irina Erenburg) at Massachusetts General Hospital (MGH), Harvard Medical School set up an incubator company known as Blossom innovations and sub-licensed these technologies back from MGH for further development. Subsequently, these technologies have been commercially transferred to R2 Dermatology in California and AVAVA LLC in Boston. Dr. CHAN has published or accepted to be published over 350 articles including 1 book, 37 book chapters and 145 peer reviewed international indexed publications (mean impact factor 3.21, total citation 3,592 and H Index: 38 (researcher ID number: L-2267-2013)). He is the Associate Editor of Lasers in Surgery and Medicine and serves on the editorial board of other international journals including the Dermatologic Surgery, Lasers in Medical Science, Journal of Cosmetic and Laser Therapy and Archives of Dermatological Research.

ABSTRACT

Psoriasis is regarded as a T-cell-mediated inflammatory disease, and patients with psoriasis are at higher risk of developing systemic comorbidities, including cardiovascular disease and metabolic syndrome. In the skin and blood of patients with psoriasis, Th1 and Th17 inflammatory cytokines are elevated, and these cytokines have pleiotropic effects on diverse processes such as angiogenesis, insulin signaling, adipogenesis, lipid metabolism, and immune cell trafficking. This may explain the linkage between psoriasis and comorbid disease conditions.

Our group examined the relationship between psoriasis as a chronic skin inflammatory disease and cardiovascular abnormalities including arterial stiffness. We then examine the prevalence of extent of subclinical atherosclerosis among psoriasis patient vs age and matched control. We then further established the role of reduce endothelial progenitor cells among psoriasis patients that contribute to vascular abnormalities.

Evolving concepts in psoriasis pathogenesis lead to the current understanding of interleukin-23 (IL-23) being a master regulatory cytokine in this skin disease. In turn, IL-23 inhibitors were subsequently developed as novel treatment. Blockade of IL-23 inhibits the formation of "pathogenic" T-helper (Th) 17 cells, resulting in longer term reduction of the release of downstream cytokines including IL-17.

Randomized clinical trials have already demonstrated relatively high rates of PASI 90/100 response of IL-23 inhibitors such as guselkumab and risankizumab up to 1 year. Recent long-term data further confirm that guselkumab was able to maintain the high response rates through 5 years (PASI 90/100 response rates up to 87%/54% respectively), with no new safety concerns being identified.

The use of biologics in psoriatic patients with systemic comorbidities has not been indicated, but a recent study indicated that the efficacy and safety of an IL-23 inhibitor were not largely affected in those with metabolic syndrome.

We recently demonstrated change in skin microbiomes among psoriasis as compared with control and this may offer future means to early detect or prevent the development of psoriasis.

Symposium II: Advances in the Treatment of Psoriasis

Achieving Sustainable PASI100 - The New Normal

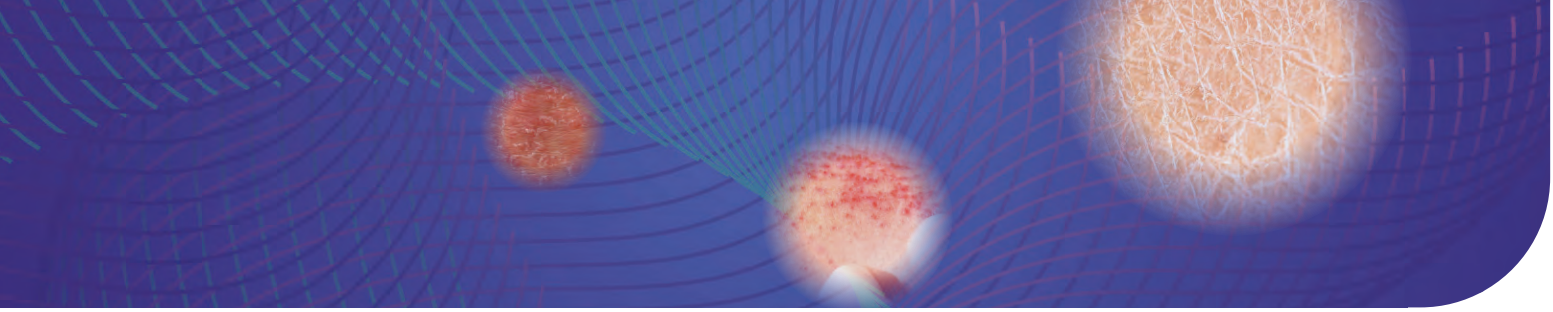
Dr. Johnny CHAN
Honorary Clinical Assistant Professor, Division of Dermatology, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Johnny CHAN is the director of dermatology at the Hong Kong Sanatorium & Hospital. He is also the honorary clinical assistant professor of the Department of Medicine at the University of Hong Kong. Since his time as academic staff in the University, he had involved in various international multi-centre clinical trials in the field of psoriasis and atopic dermatitis. His research interests include clinical phenotypes and pharmacogenetics of severe cutaneous adverse reactions (SCAR) of drugs, establishment of a local territory-wide database of SCAR in Hong Kong, and the long term systemic complications and new advances in psoriasis therapies.

ABSTRACT

Dermatologists have seen significant advancement in the management of psoriasis in recent years thanks to targeted biologics such as IL-17 and IL-23 inhibitors. Achieving clear or almost clear skin is now possible for patients with psoriasis and marks the new therapeutic target in the patient journey. Such new standard of care brings in enhanced patients' satisfaction, quality of life, and hence better social integration.

In this session, latest comparative data on psoriasis therapies will be discussed and the real-life therapeutic considerations in choosing among various biological will be illustrated through case studies.



Symposium II: Advances in the Treatment of Psoriasis

The Importance of Achieving Complete Skin Clearance That Lasts and the Implications of Rapid Onset for Patient Treatment Satisfaction

Dr. Piergiorgio MALAGOLI
Head of PsoCare Unit and Dermatology, IRCCS Policlinico San Donato, Milan, Italy

Dr. Piergiorgio MALAGOLI was born in Milan in April 1964 and achieved his graduation in classical studies at Leone XIII Milan in July 1983. In June 1991, he achieved the graduation with honors in Medicine and Surgery at the University of Medicine and Surgery of Pavia. In 1996, he achieved with honors the specialization in Dermatology and Venereology at the University of Medicine and Surgery of Pavia. Since 1997, he works like dermatologist at the Istituto Policlinico San Donato in Milan. In 2006 he was appointed Director of Psocare and Atopic Dermatitis unit at the Istituto Policlinico S. Donato in Milan. He is Principal Investigator in many Phase II and III Control Trials Studies on new molecules for the treatment of Psoriasis and Atopic Dermatitis. He is also the Founder of Italian Skin Consulting, consulting company for Market Research, Market Strategy and Study Design.

ABSTRACT

In Psoriasis, as all of you know, the goal is to achieve clear skin and quickly, if possible. Now we can answer to the unmet needs of our patients. Ixekizumab symbolize the answer. We'll try to read inside the RCT'S what we could transfer in our Real Life Treatment. We'll analyze sustained response over five years of treatment with Ixekizumab, matching DLQI and PASI.

Infact, as better we improve skin lesions, the higher it will be the number of patients having a DLQI 0 or 1, which means no effect on the quality of life. We will stress the difference between PASI 75, PASI 90 and PASI 100. With Ixekizumab we can achieve absolute PASI 0-2 in most of the patients undergoing the treatment. This must be the driver to choose between the different molecules that, today, the Dermatologists have in their professional portfolio. The patients of our Real Life are, often, much more complicated to treat in comparison with patients enrolled in RCT studies.

An overview of Ixekizumab in Real Life patients is essential to understand how could we be confident in our treatment choice.

In conclusion, focus on the value of complete skin clearance and the patient outcomes of a quick response: we'll surf on the waves of the RCT'S studies and we'll explore Ixekizumab Real World Evidence.

State-of-the-Art Lecture (sponsored by Sanofi Hong Kong Limited)

The Game Changer for Moderate-to-Severe Atopic Dermatitis in Adolescents

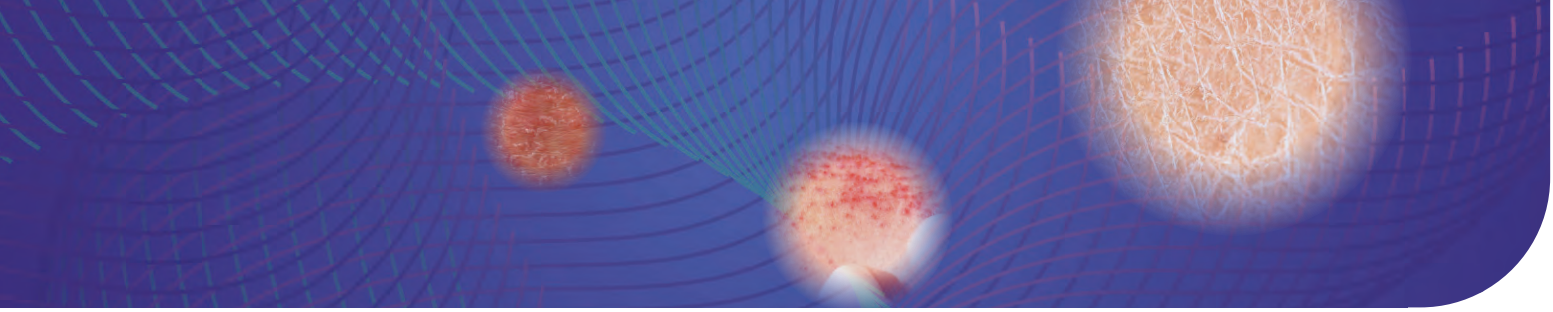
Dr. Chih-ho HONG
Clinical Assistant Professor, Department of Dermatology and Skin Sciences, St. Paul's Hospital, Vancouver, Canada

Dr. Chih-ho HONG is a board certified dermatologist working in Greater Vancouver BC, Canada. He runs a busy office based dermatology clinic with a focus on clinical research. He is a Clinical Assistant Professor in the Department of Dermatology and Skin Sciences and teaches at St. Paul's Hospital in Vancouver, where he is active staff. Dr. HONG is the past head of the BC Section of Dermatology, the current Economics representative for Dermatology at the BCMA, and is the past chair of the Education Committee of the Canadian Dermatology Association. He is also a past examiner in Dermatology for the Royal College of Physicians of Canada residency qualification examination.

Dr. HONG is currently the Canadian representative to SPIN (The Skin Inflammation and Psoriasis International Network – www.spindermatology.org. He is active in clinical practice and dermatology research. His main clinical areas of interest are psoriasis and eczema. He has been an investigator in over 100 trials of treatments in dermatology and has over 30 peer reviewed publications. He has lectured locally, nationally, and internationally on dermatology treatments and has been an invited speaker at international dermatology congresses.

ABSTRACT

Atopic dermatitis (AD) is a chronic, pruritic immune-mediated inflammatory dermatosis characterized by a T helper 2 (Th2) immune response phenotype and may be associated with systemic inflammation. Adolescents with AD have high disease burden negatively affecting quality of life, with limited treatment options. Blockade of IL-4/13 is effective in reducing Th2 response. Dupilumab is an interleukin 4 (IL-4) receptor □-antagonist that inhibits IL-4 and IL-13 signaling through blockade of the shared IL-4□ subunit. Biomarker analyses show that dupilumab modulates the AD molecular signature and other Th2-associated biomarkers. Dupilumab has recently been approved in Hong Kong for the treatment of adolescent patients with moderate-to-severe AD. Clinical trials have shown that adolescents with moderate-to-severe AD who receive biweekly dupilumab injections have significantly improved clinical and patient-reported outcomes. Common adverse events reported in the clinical trials were nasopharyngitis, upper respiratory tract infection, injection site reactions, skin infections, and conjunctivitis. These were mild-to-moderate in nature, and overall rates of adverse events occurred with similar frequency between the treatment and placebo groups. There were no significant serious safety concerns identified in phase III clinical trials. Apart from discussion of the trial data, a few real life clinical cases shall be shared to demonstrate the benefit my adolescent patients derived from the use of the new biologic for AD.



Symposium III: Interesting Cases Sharing

Scalp Biopsy in Alopecia

Dr. Paul CHOI (Hong Kong)

Consultant, Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, Hong Kong

Dr. Mimi CHANG (Hong Kong)

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Dr. Paul CHOI is a consultant pathologist of Department of Anatomical & Cellular Pathology, Prince of Wales Hospital and Honorary Clinical Associate Professor of Department of Anatomical & Cellular Pathology, Chinese University of Hong Kong. He has interest in dermatopathology and he studied dermatopathology at University of California, San Francisco in 1998 under the guidance of Dr. Philip LeBoit and Tim McCalmont. He has been responsible for reporting all skin biopsies of Prince of Wales Hospital for more than 20 years.

Dr. Mimi CHANG graduated from the Chinese University of Hong Kong in 2003 with distinction in Medicine. She completed her basic and higher physician training in the Prince of Wales Hospital (PWH), obtaining her MRCP in 2006 and fellowships in Dermatology and Venereology and Advanced Internal Medicine in 2012. She was a clinical fellow in the Singapore National Skin Center during residency and pursued subspecialty training in trichology and in skin cancer and nail surgery in Switzerland and Germany post-fellowship. Dr. CHANG was the Chief of Division of Dermatology and associate consultant in PWH, where she managed dermatology service, residency training and medical students teaching. She is a managing editor of the HKJDV and has contributed in local and international registries. Her subspecialty interests include hair and scalp disorders, hospital dermatology and blistering dermatoses and. She is currently in private practice and visits the PWH weekly.

ABSTRACT

Alopecia is a common complaint in the clinic setting. Non-scarring alopecia account for the majority of cases. A comprehensive evaluation includes good history taking, clinical examination, photographic and dermoscopic assessment, appropriate investigations and/or biopsy of the scalp. Scalp biopsy is not routinely done but aids the diagnosis of primary scarring alopecia and for exclusion of secondary causes. It also helps to decide treatment and offers prognostication value in other cases. It is pertinent that scalp biopsy should be done early in the course of disease of scarring alopecia. Good clinicopathologic correlation is helpful.

Symposium III: Interesting Cases Sharing

Pyoderma Gangrenosum or Necrotizing Fasciitis: A Case of Limb Salvaging Experience and and a Case Series in a Tertiary Hospital, Hong Kong

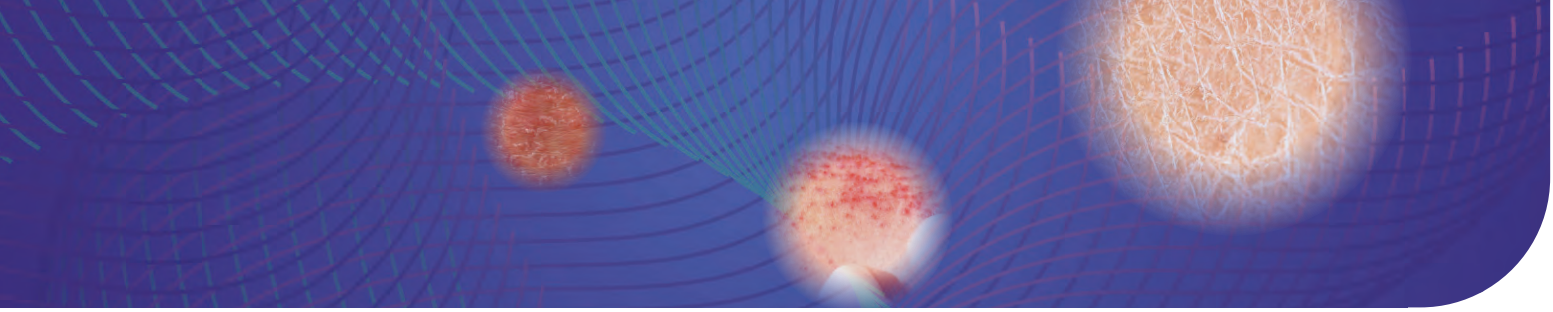
Dr. Christina WONG (Hong Kong)
Division Chief and Honorary Clinical Assistant Professor, Division of Dermatology, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Christina WONG graduated from the University of Hong Kong. She received her Master's degree in Clinical Dermatology from St John's Institute of Dermatology in King's College, London, UK and her specialist qualification in Dermatology and Venereology in Hong Kong.

Dr. WONG is now Associate Consultant, Division of Dermatology, Department of Medicine, at Queen Mary Hospital, Hong Kong. She is also Honorary Clinical Assistant Professor at the Li Ka Shing Faculty of Medicine, the University of Hong Kong. Her major research interests include novel treatment in Atopic dermatitis, Psoriasis and inflammatory dermatoses. Dr. Wong' one of the members of the Specialty Board of Dermatology and Venereology, Hong Kong College of Physicians, the Hong Kong College of Dermatologists and Hong Kong Allergy and Immunology Association.

ABSTRACT

Pyoderma gangrenosum (PG) is a rare non-infectious, inflammatory neutrophilic dermatosis that can be idiopathic or associated with underlying autoimmune or neoplastic disorders. A correct diagnosis is often challenging as there is no gold standard for diagnosis and treatment. The diagnosis of PG should be considered in managing of recurrent, chronic, non-healing ulcers to avoid unnecessary medical or surgical complications. While systemic steroid, and immune-suppressants form the mainstay of treatment options, biologics and small molecules therapies are emerging therapy for PG. A 38-year old lady presented with rapidly deteriorating 'cellulitis' with bulla and extensive suppuration. Clinically, 'necrotizing fasciitis' was suspected with multiple debridement performed but in vain. Subsequently, a clinical diagnosis of PG was made just before amputation of the right foot. The patient responded significantly after systemic pulsed methylprednisolone therapy. A small case series of confirmed PG in a tertiary hospital will be reviewed with treatment used and clinical response.



Symposium III: Interesting Cases Sharing

Erythroderma in a Patient with Thymoma and Severe Pneumonia

Dr. William NGAN (Hong Kong)
Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

Dr. William NGAN is currently a Medical and Health Officer at the Social Hygiene Service, Department of Health. He obtained his medical degree from The University of Hong Kong, completed his basic physician training in Queen Mary Hospital, before joining the Department of Health.

ABSTRACT

Erythroderma is a bread and butter topic in inpatient dermatology. In this session, Dr. NGAN will present a special case of erythroderma in a patient with thymoma and severe pneumonia. Histology slides would also be presented.

ACKNOWLEDGEMENTS

The Organizing Committee would like to extend their heartfelt thanks to the following sponsors for their support to the Joint Annual Scientific Meeting 2020.

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Notes

Notes

Skyrizi™ (risankizumab)

The potential for **nothing left on their skin:*** To patients, that's everything[1-4]

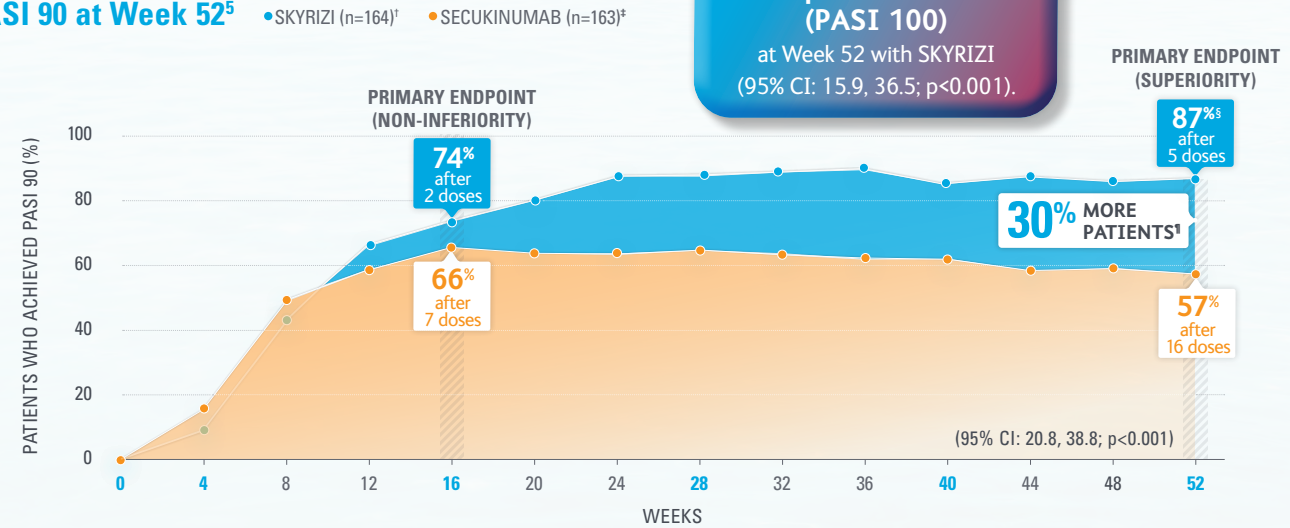
NOTHING IS EVERYTHING

New IMMerge head-to-head data:

SKYRIZI DEMONSTRATED SUPERIORITY VS SECUKINUMAB AT WEEK 52 IN A PHASE 3B STUDY[5]

DURABLE CLEARANCE

PASI 90 at Week 52[5]



†SKYRIZI doses denoted in blue: Participants received 150 mg SKYRIZI at Week 0, Week 4, and every 12 weeks thereafter.[5]
‡Secukinumab is dosed 300 mg at Week 0, Week 1, Week 2, Week 3, Week 4, and every 4 weeks thereafter.
§p<0.001 vs secukinumab.
¶30% more patients achieved PASI 90 at Week 52 with SKYRIZI (95% CI: 20.8, 38.8).[5]

SKYRIZI vs secukinumab head-to-head IMMerge study design[5]

A Phase 3b, multicenter, randomized, open-label, efficacy assessor-blinded, active-comparator study designed to evaluate the safety and efficacy of SKYRIZI compared with secukinumab in adult patients with moderate to severe plaque psoriasis. Patients were randomized 1:1 to receive SKYRIZI (n=164) (150 mg), given as two 75 mg subcutaneous injections at baseline, 4 weeks later, and every 12 weeks thereafter or secukinumab (n=163) (300 mg) given as two 150 mg subcutaneous injections, at baseline, Weeks 1, 2, 3, and 4, and then every 4 weeks thereafter. Safety was assessed in all patients.

Primary endpoints
PASI 90 at Week 16 (non-inferiority)
PASI 90 at Week 52 (superiority)

Ranked secondary endpoints
PASI 100, sPGA 0/1 and PASI 75 at Week 52

Data analysis: Missing data were imputed as non-responders (NRI) for all primary and ranked secondary endpoints.

Study safety

- Rates of serious adverse events: 5.5% SKYRIZI vs 3.7% secukinumab
- Adverse events leading to discontinuation: 1.2% SKYRIZI vs 4.9% secukinumab[5]

Indication[1]: SKYRIZI (risankizumab) is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy.
*Nothing on the skin: Defined as achievement of 75% PASI 90 and ≥84% sPGA 0/1 at Week 16 and achievement of ≥56% PASI 100 and sPGA 0 at Week 52 in UltIMMa-1 and UltIMMa-2.[4]
UltIMMa-1 & -2 (N=506/491) were replicate phase 3, multi-national, 52-week, randomized, double-blind, placebo-controlled, active-comparator, controlled trials. Patients ≥18 years with moderate to severe plaque psoriasis were stratified by weight and previous exposure to TNF inhibitor, and were randomly assigned (3:1:1) to receive subcutaneous risankizumab 150 mg, ustekinumab 45 mg or 90 mg (based on label), or placebo. Dosing occurred at Weeks 0 and 4 (Part A) and Weeks 16, 28 and 40 (Part B). Following the 16-week placebo-controlled treatment period (Part A), patients initially assigned to placebo switched to 150 mg of risankizumab at Week 16. Other patients continued double blind with their originally randomized treatment (Part B) for Week 16 to 52. Co-primary endpoints were proportions of patients achieving PASI 90 and sPGA 0/1 at Week 16 (NRI). All efficacy analyses were done in the ITT population.[1,4]

CI, confidence interval; ITT, intent-to-treat; PASI, Psoriasis Area and Severity Index; sPGA, static Physician's Global Assessment.

SKYRIZI™ abbreviated prescribing information
Presentation: 75mg risankizumab per 0.83ml as a solution for injection in a pre-filled syringe. **Indication:** Treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Dosage and administration:** 150 mg (two 75mg injections) via SC injection at week 0, week 4, and every 12 weeks thereafter. **Contraindications:** Patients with known hypersensitivity to risankizumab or any of its excipients. Patients with clinically important active infections like active tuberculosis. **Warning and Precautions: Infections:** Risankizumab may increase the risk of infections and should be used in caution in patients with chronic infections, history of recurrent infections or those with known risk factors for infection. Do not initiate treatment with risankizumab in patients with a clinically important active infection until it resolves or is adequately treated. **Tuberculosis (TB):** Patients should be evaluated for TB prior to initiating treatment with risankizumab and patients on treatment should be monitored for signs and symptoms of TB. **Immunisations:** Completion of all appropriate immunisations according to current immunisation guidelines should be considered prior to initiating treatment with risankizumab. If a patient has received live vaccination, it is recommended to wait at least 4 weeks prior to starting treatment with risankizumab. Patients treated with risankizumab should not receive live vaccines during treatment and for at least 21 weeks after treatment. **Pregnancy:** There are no or limited amount of data from the use of risankizumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of risankizumab during pregnancy. **Women with childbearing potential:** Use an effective method of contraception during treatment and for at least 21 weeks after treatment. **Breast feeding:** It is unknown whether risankizumab is excreted in human milk. A decision should be made whether to discontinue/abstain from risankizumab therapy, taking into account the benefit of breast-feeding to the child and the benefit of risankizumab therapy to the woman. **Interactions:** Risankizumab is not expected to undergo metabolism by hepatic enzymes or renal elimination. Drug interactions between risankizumab and inhibitors, inducers, or substrates of drug metabolizing enzymes are not expected and no dose adjustment is needed. The safety and efficacy of risankizumab in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. **Undesirable effects:** Respiratory tract infection; tinea infections; headache; pruritus; fatigue; injection site reactions. **API.HK.SKY.0519.**

References: 1. SKYRIZI Hong Kong prescribing information, version May 2019. **2.** Blome C, Gosau R, Radtke MA, et al. Patient-relevant treatment goals in psoriasis. *Arch Dermatol Res.* 2016;308(2):69–78. doi:10.1007/s00403-015-1613-8. **3.** Ryan C, Puig Z, Zema C, et al. Incremental benefits on patient-reported outcomes for achieving PASI 90 or PASI 100 over PASI 75 in patients with moderate to severe psoriasis. Poster presented at: 2018 European Academy of Dermatology and Venerology (EADV) Congress; September 12–16, 2018; Paris, France. Poster 2002. **4.** Gordon KB, Strober B, Lebwohl M, et al. Efficacy and safety of risankizumab in moderate-to-severe plaque psoriasis (UltIMMa-1 and UltIMMa-2): results from two double blind, randomised, placebo-controlled and ustekinumab controlled phase 3 trials. *Lancet*. 2018;392(10148):650–661. doi:10.1016/S0140-6736(18)31713-6. **5.** Warren RB, Blauvelt A, Poulin Y, et al. Efficacy and safety of risankizumab vs secukinumab in patients with moderate-to-severe plaque psoriasis (IMMerge): Results from a phase 3, randomised, open-label, efficacy assessor-blinded clinical trial. *Br J Dermatol* 2020. Doi: 10.1111/bjd.19341. E-pub ahead of print.

Full local prescribing information is available upon request. All adverse events should be reported to drugsafety.pv@abbvie.com.

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ONEXTON®
(Clindamycin Phosphate and Benzoyl Peroxide) Gel, 1.2%/3.75%

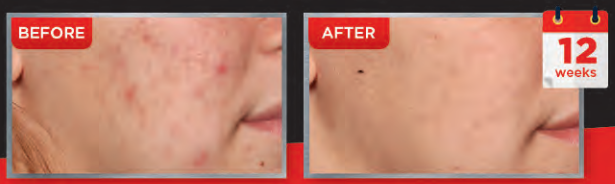
The equalibrium between

Efficacy and Tolerability

Proven Safety
No discontinuation due to TEAE* in clinical trials.[1]

Formulated for Acne
Preservative-free, surfactant-free and alcohol-free[2]

Patient treated with ONEXTON® Gel[3,#]



*TEAE: Treatment-Emergent Adverse Event

Photos have not been retouched. Individual results may vary.

References: 1. Pariser DM, Rich P, Cook-Bolden FE, Korotzer A. An aqueous gel fixed combination of clindamycin phosphate 1.2% and benzoyl peroxide 3.75% for the once-daily treatment of moderate to severe acne vulgaris. J Drugs Dermatol. 2014;13(9):1083-1089. **2.** ONEXTON Gel HK prescribing information. **3.** Data on file. "Acne? Stop Hiding Start Fighting"

Indication: ONEXTON Gel is a combination of clindamycin phosphate (a lincosamide antibacterial) and benzoyl peroxide indicated for the topical treatment of acne vulgaris in patients 12 years of age and older.

Important Safety Information
Contraindictaion: Hypersensitivity: ONEXTON Gel is contraindicated in those individuals who have shown hypersensitivity to clindamycin, benzoyl peroxide, any components of the formulation, or lincomycin. Anaphylaxis, as well as allergic reactions leading to hospitalization, has been reported in postmarketing use with ONEXTON Gel. **Colitis/Enteritis** ONEXTON Gel is contraindicated in patients with a history of regional enteritis, ulcerative colitis, or antibiotic-associated colities. **Warning and precautions: Colitis** Systemic absorption of clindamycin has been demonstrated following topical use of clindamycin. Diarrhea, bloody diarrhea, and colitis (including pseudomembranous colitis) have been reported with the use of topical and systemic clindamycin. If significant diarrhea occurs, ONEXTON Gel should be discontinued. Severe colitis has occurred following oral and parenteral administration of clindamycin with an onset of up to several weeks following cessation of therapy. Antiperistaltic agents such as opiates and diphenoxylate with atropine may prolong and/or worsen severe colitis. Severe colitis may result in death. Studies indicate toxin(s) produced by Clostridia is one primary cause of antibiotic-associated colitis. The colitis is usually characterized by severe persistent diarrhea and severe abdominal cramps and may be associated with the passage of blood and mucus. Stool cultures for Clostridium difficile and stool assay for C. difficile toxin may be helpful diagnostically. **Ultraviolet Light and Environmental Exposure** Minimize sun exposure (including use of tanning beds or sun lamps) following drug application.

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HK-PH-2020-06-013

FOR ADULTS WITH MODERATE TO SEVERE PLAQUE PSORIASIS

Offer a Chance for

Completely Clear Skin.

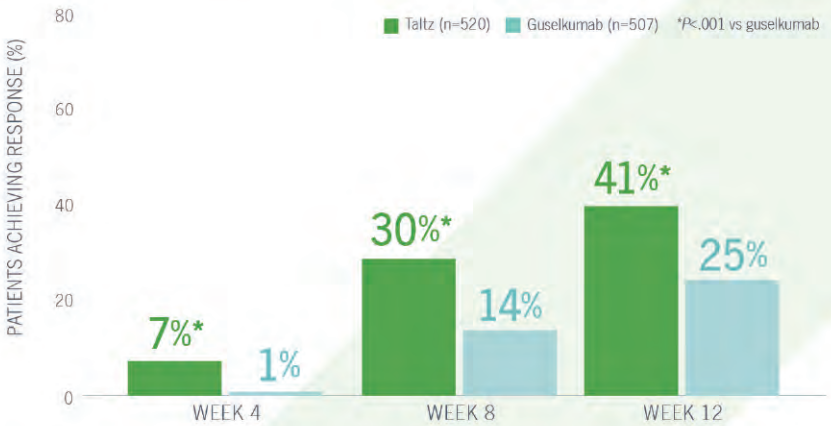
Rapid + Sustained

taltz® (ixekizumab)

Rapid, superior and complete clearance[1]

Taltz was superior to guselkumab in the percentage of patients achieving PASI 100 at weeks 4, 8 and 12

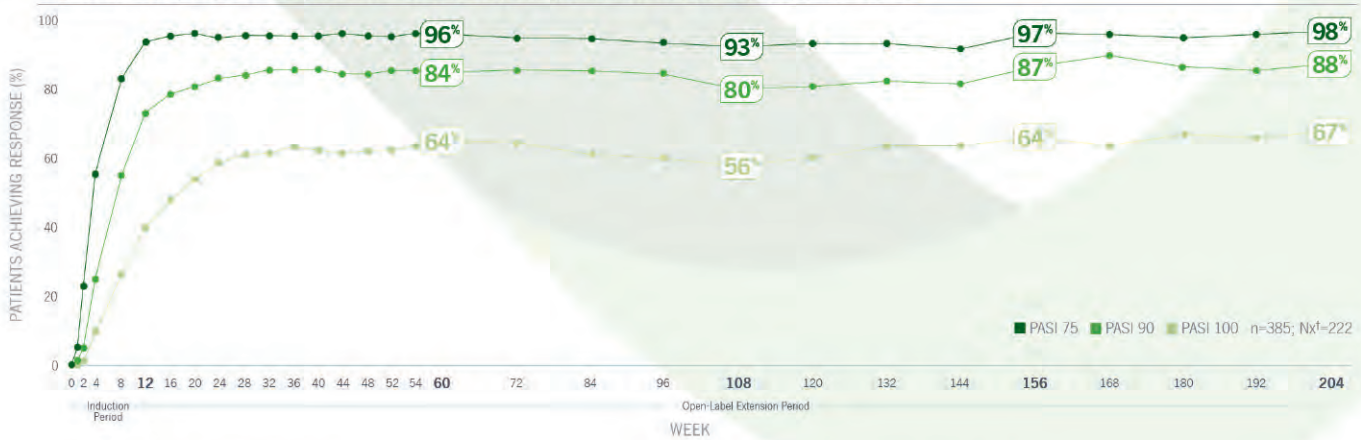
IXORA-R: PERCENTAGE OF PATIENTS ACHIEVING **PASI 100** AT WEEKS 4, 8, AND 12, NRI[§]



Sustained skin clearance over 4 years of treatment[2]

Over 60% of patients achieved or maintained PASI 100 through week 204

UNCOVER-3: PASI 75, PASI 90, AND PASI 100 OBSERVED RESULTS AT WEEKS 60, 108, 156, AND 204



NRI = Non-responder imputation. PASI = Psoriasis Area Severity Index.

[§]NRI: Missing data is imputed by the non-responder imputation in which all patients with missing data are considered non-responders for that visits. †Nx: observed population at week 204.

References: 1. Blauvelt A, et al. Poster Presentation: Ixekizumab demonstrated superiority vs guselkumab in achieving PASI 100 at week 12 in head-to-head study. 5th Annual Maui Derm NP+PA Fall meeting. Oct 2-5, 2019. **2.** Lebwohl MG, et al. J Eur Acad Dermatol Venerol. 2019. doi: 10.1111/jdv.15921.

Taltz Abbreviated Prescribing Information

Indications: Plaque psoriasis - Taltz is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Psoriatic arthritis** - Taltz, alone or in combination with methotrexate, is indicated for the treatment of active psoriatic arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drug (DMARD) therapies. **Dosage: Plaque psoriasis** - Recommended dose is 160 mg by subcutaneous injection (two 80 mg injections) at Week 0, followed by 80 mg (one injection) at Weeks 2, 4, 6, 8, 10, and 12, then maintenance dosing of 80 mg (one injection) every 4 weeks. **Psoriatic arthritis** - Recommended dose is 160 mg by subcutaneous injection (two 80 mg injections) at Week 0, followed by 80 mg (one injection) every 4 weeks thereafter. For psoriatic arthritis patients with concomitant moderate to severe plaque psoriasis, the recommended dosing regimen is the same as for plaque psoriasis. No data are available in children and adolescent ≤ 18 years and limited information in subjects ≥ 75 years. **Contraindications:** Serious hypersensitivity. Clinically important active infections. **Special Precautions:** Infections, hypersensitivity, inflammatory bowel disease, immunization. Pregnancy, breast-feeding, fertility. **Adverse Reactions:** Injection site reactions, upper respiratory tract infections, tinea infection, oropharyngeal pain, nausea.

Please see Important Safety Information in the full prescribing information.
Please see Instructions for Use included with the device.

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PP-IX-HK-0052 11/2019

Tremfya® (guselkumab)

Stay Clear

First Approved IL-23 Inhibitor[1]

Around 84.3% of patients sustained PASI 90 response after **4-year** moderate to severe psoriasis treatment[2]

PASI 100 Response

Rapid onset of response

76.8% of Tremfya® super responders achieved PASI 100 response at week 16*[3]

Low Immunogenicity

Up to week 52, only 0.4% of patients treated with Tremfya® developed neutralising antidrug antibodies†[4]

Convenience

6 injections per year after first year of treatment‡[4]

*Data refer to responses of super responders (n=271) with Tremfya®. Super responders were defined as the patients who achieved PASI 100 response at both week 20 and 28 with Tremfya® treatment.
†Data refer to the clinical data of pooled clinical trials (VOYAGE 1 and VOYAGE 2). 1441 patients were assigned to 3 groups: Tremfya® (n=823), adalimumab (n=196) and placebo (n=422).
‡A single Tremfya® 100 mg injection is needed every 8 weeks after starting the injections at week 0 and 4.

Study design[3]:
VOYAGE 1 through 28 weeks was a phase 3, randomised, double-blind, placebo and active comparator-controlled trial. Among the pooled patient population (n=1829), only patients randomised to Tremfya® (n=664) were included in post hoc descriptive analysis. The primary endpoint was the proportion of patients achieving PASI 90 response in Tremfya® group compared with placebo group at week 16.

IL-23=interleukin-23. PASI=psoriasis area severity index.

References:
1. Yang EJ, Smith MP, Ly K, et al. Evaluating guselkumab: An anti-IL-23 antibody for the treatment of plaque psoriasis. Drug Design, Development and Therapy. 2019; 13:1993-2000.
2. Griffiths CEM, Papp KA, Song M, et al. Maintenance of response with up to 4 years of continuous guselkumab treatment: results from the VOYAGE 1 phase 3 trial. Poster. The 39th Annual Fall Clinical Dermatology Conference. Las Vegas, USA, 17-20 October 2019.
3. Reich K, Gordon KB, Strober B, et al. Characterization of Super Responders to Guselkumab Treatment in Moderate-to-Severe Psoriasis: Results From the VOYAGE 1 and 2 Clinical Trials. Poster. American Academy of Dermatology's Virtual Meeting Experience, 12-14 June 2020.
4. Tremfya® Hong Kong prescribing information.

ABBREVIATED PRESCRIBING INFORMATION
ACTIVE INGREDIENT(S): Guselkumab
INDICATION(S): Treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. DOSAGE & ADMINISTRATION: 100 mg by subcutaneous injection at weeks 0 and 4, followed by maintenance dose every 8 weeks. Consider discontinuing treatment in patients who have shown no response after 16 weeks of treatment. Safety and efficacy in children and adolescents below 18 years old have not yet been established. If possible, areas of skin that show psoriasis should be avoided as injection sites. CONTRAINDICATIONS: Serious hypersensitivity to the active substance or to any of the excipients. Clinically important active infections (e.g., active tuberculosis(TB)). SPECIAL WARNINGS & PRECAUTIONS: Infections: Tremfya may increase risk of infection. Do not initiate Tremfya in patients with any clinically important active infection until the infection resolves or is adequately treated. If a patient develops a clinically important or serious infection or is not responding to standard therapy, monitor the patient closely and discontinue Tremfya until the infection resolves. Pre-treatment evaluation for TB: Prior to initiating Tremfya, evaluate patients for TB infection. Monitor patients receiving Tremfya for signs and symptoms of active TB during and after treatment. Anti-TB therapy should be considered prior to initiating Tremfya in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Hypersensitivity: If a serious hypersensitivity reaction occurs, discontinue Tremfya immediately and initiate appropriate therapy. Immunisations: Prior to initiating Tremfya, consider completion of all appropriate immunisations. Do not use live vaccines concurrently in patients treated with Tremfya. Before live viral or live bacterial vaccination, Tremfya should be withheld for at least 12 weeks after the last dose and can be resumed at least 2 weeks after vaccination. SIDE EFFECTS: Upper respiratory infection. Refer to the full prescribing information for other side effects. PREGNANCY & LACTATION: It is preferable to avoid use of Tremfya in pregnancy. A decision should be made whether to discontinue breast-feeding during treatment and up to 12 weeks after the last dose, or to discontinue Tremfya, taking into account the benefit of breast-feeding to the child and the benefit of Tremfya therapy to the woman. INTERACTIONS: No need for dose adjustment when co-administering guselkumab and CYP450 substrates. Safety and efficacy of Tremfya in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated.
PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.
API version to be quoted on promotional material: Tremfya aPI ver 1.0

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CP-170438 Sep 2020

Cosentyx®
secukinumab
可善挺®

Psoriatic disease is deeper than skin

Start early with The Complete Cosentyx Approach*

Psoriatic disease may be progressing inside the body, even if the skin looks clear.[1]
With **The Complete Cosentyx Approach**, you can address the underlying cause of the disease—and **decrease systemic inflammation.**[2]

Look Better

Fast and sustained long-term efficacy in skin and persistent troublesome areas[3-6]

Move Better

Helps prevent future irreversible joint damage.[7]
Joint relief for patients with PsA, including Axial symptoms[8]

Feel Better

Fast and significant improvement in **quality of life**[4,9]

Make Cosentyx your priority for the best patient outcomes

Indications

♦ **Plaque psoriasis:** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. ♦ **Psoriatic arthritis:** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease modifying anti rheumatic drug (DMARD) therapy has been inadequate. ♦ **Ankylosing spondylitis:** Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy.[10]

*The Complete Cosentyx Approach is defined as efficacy in both skin and persistent psoriasis manifestation in nails, scalp, palms, and soles, as well as psoriatic arthritis; controls irreversible structural damage (PsA) and improves quality of life.
PsA=psoriatic arthritis.

References: 1. Duffin KC et al. *Dermatology*. 2020 [Epub ahead of print]. **2.** Krueger J et al. 24th World Congress of Dermatology. 10-15 June 2019; Milan, Italy. Poster 505. **3.** Langley RG et al. *N Engl J Med*. 2014;371(4):326-338. **4.** Bissonnette R et al. *J Eur Acad Dermatol Venereol*. 2018;32(9):1507-1514. **5.** Reich K et al. *Br J Dermatol*. 2019;181(5):954-966 **6.** Reich K et al. *J Eur Acad Dermatol Venereol*. 2019 [Epub ahead of print] **7.** Novartis data on file. CAIN457F2342 (FUTURE 5): Week 104 Interim Report. April 2019. **8.** Baraliakos X et al. *Ann Rheum Dis*. 2019;78. 195-196. **9.** Strober B et al. *J Am Acad Dermatol*. 2017;76(4):655-661. **10.** Cosentyx Hong Kong Prescribing Information. Jul 2016.

Cosentyx®
Important note: Before prescribing, consult full prescribing information. **Presentation:** Secukinumab. Powder for solution for subcutaneous injection, solution for subcutaneous injection in pre-filled syringe or pre-filled pen contain 150 mg of secukinumab. **Indications: Plaque psoriasis:** Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. **Psoriatic arthritis:** Cosentyx, alone or in combination with methotrexate (MTX), is indicated for the treatment of active psoriatic arthritis in adult patients when the response to previous disease modifying anti rheumatic drug (DMARD) therapy has been inadequate. **Ankylosing spondylitis:** Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. **Dosage and administration:** Dosage **Plaque psoriasis:** The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. **Psoriatic arthritis:** The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. For patients who are anti-TNFα inadequate responders or patients with concomitant moderate to severe plaque psoriasis, the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. **Ankylosing spondylitis:** The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response by 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. ♦ **Paediatric population (aged below 18 years):** The safety and efficacy of Cosentyx in children below the age of 18 years have not yet been established. No data are available. ♦ **Renal impairment / hepatic impairment:** Cosentyx has not been studied in these patient populations. No dose recommendations can be made. Administration Cosentyx is to be administered by subcutaneous injection. If possible, areas of the skin that show psoriasis should be avoided as injection sites. **Contraindications:** ♦ Cosentyx is contraindicated in patients who have/had severe hypersensitivity reactions reaction to the active substance or to any of the excipients. ♦ Clinically important, active infection (e.g. active tuberculosis) **Warnings and precautions:** ♦ **Infections:** Cosentyx has the potential to increase the risk of infections. Caution in patients with chronic or history of recurrent infection. If a patient develops a serious infection, the patient should be closely monitored and Cosentyx should not be administered until the infection resolves. Anti-tuberculosis therapy should be considered prior to initiation of Cosentyx in patients with latent tuberculosis. Cosentyx should not be given to patients with active tuberculosis. ♦ **Crohn's disease:** Patients with active Crohn's disease treated with Cosentyx should be followed closely. ♦ **Hypersensitivity reactions:** In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving Cosentyx. Administration of Cosentyx should be discontinued immediately and appropriate therapy initiated if an anaphylactic or other serious allergic reaction occurs. ♦ **Latex-sensitive individuals:** The removable cap of the Cosentyx pre-filled syringes/pen contains a derivative of natural rubber latex. ♦ **Vaccinations:** Cosentyx should not be given concurrently with live vaccines. Patients receiving Cosentyx may receive concurrent inactivated or non-live vaccinations. ♦ **Concomitant immunosuppressive therapy:** In psoriasis studies, the safety and efficacy of Cosentyx in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. **Women of childbearing potential:** Effective method of contraception during treatment and for at least 20 weeks after treatment should be used. **Pregnancy:** There are no adequate data from the use of secukinumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of Cosentyx in pregnancy. **Breast-feeding:** It is not known whether secukinumab is excreted in human milk. Because of the potential for adverse reactions in nursing infants from secukinumab, a decision on whether to discontinue breast feeding during treatment and up to 20 weeks after treatment or to discontinue therapy with Cosentyx must be made taking into account the benefit of breast feeding to the child and the benefit of Cosentyx therapy to the woman. **Adverse drug reactions: Very common (≥10%):** Upper respiratory tract infections. **Common (1 to <10%):** Oral herpes, diarrhea, rhinorrhea. **Uncommon (0.1 to <1%):** Oral candidiasis, neutropenia, otitis externa, tinea pedis, conjunctivitis, urticaria. **Rare (0.01 to <0.1%):** Anaphylactic reactions. **Interactions:** Live vaccines should not be given concurrently with Cosentyx. Therapeutic monitoring should be considered when using Cosentyx with CYP450 substrates with a narrow therapeutic index, where the dose is individually adjusted (e.g. warfarin). No interaction was seen when Cosentyx was administered concomitantly with methotrexate (MTX) and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and ankylosing spondylitis). **Packs and prices:** Powder in Vial: 1's. Solution in pre-filled syringe: 1's or 2's. Solution in pre-filled pen; 1's or 2's. Not all pack sizes are marketed. **Legal classification:** P1S1S3. Ref: EMA Apr 2016

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

HK/0030065132

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NOVARTIS

Staquis™

crisaborole ointment 2% w/w

FIRST STEROID-FREE TOPICAL PDE4 INHIBITOR[1]

in Hong Kong for the treatment of mild to moderate atopic dermatitis[2]

2 **times daily**
to affected areas[2] , no limit to sensitive areas*[3]

4 **days**
to reduce pruritus[4,5]

8 **days**
to achieve ISGA success[2,6]

29 **days**
>30% patients achieved an ISGA success of clear (0) or almost clear (1) [2,6-8]

48 **weeks treatment period**
77.8% patients did not require the use of a TCS/TCI[9]

Prescribe STAQUIS™ (crisaborole) so your patients can stay under your care, even when you're not there

*STAQUIS™ (crisaborole) is for topical use only and not for ophthalmic, oral, or intravaginal use. #Success is defined as an ISGA score of Clear (0) or Almost Clear (1) with a 2-grade or greater improvement from baseline. PDE4=phosphodiesterase 4; ISGA=Investigator's Static Global Assessment; TCI=topical calcineurin inhibitor; TCS=topical corticosteroid

References: 1. Kaufman MB. Pharmaceutical Approval Update. P T. 2017;42(2):90-91. 2. Staquis™ (crisaborole) Hong Kong Prescribing Information. Pfizer Corporation Hong Kong Limited: Version November 2019. 3. Zane LT et al. Tolerability of Crisaborole Ointment for Application on Sensitive Skin Areas: A Randomized, Double-Blind, Vehicle-Controlled Study in Healthy Volunteers. Am J Clin Dermatol 2016. 4. Data on file. AD HOC. Pfizer, Inc., New York, NY. 5. Yosipovitch G et al. Effect of crisaborole topical ointment, 2%, on atopic dermatitis-associated pruritus: an extended analysis of 2 phase 3 clinical trials. Itch. 2018;3(2). 6. Data on file. CSR AD-302. Pfizer, Inc., New York, NY. 7. Paller AS et al. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016;75(3):494-503. 8. Data on file. CSR AD-301. Pfizer, Inc., New York, NY. 9. Data on file. Pfizer, Inc., New York, NY. 10. Eichenfield F et al. Long-term safety of Crisaborole ointment 2% in children and adults with mild to moderate atopic dermatitis. J Am Acad Dermatol 2017;77:641-49.

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PP-STA-HKG-0001 Sep 2020

LUMICEF®
Brodalumab injection 210 mg/1.5 mL

Embrace a New Life with PASI 100

☑ **Effective**
the first IL-17 receptor antagonist[1]

☑ **Rapid**
25% patients achieve PASI 75 in 2.1 weeks[2]

☑ **Durable**
> 50% patients maintained PASI 100 for more than 2 years[3]

References:
1. Beck K. et al. Brodalumab for the treatment of plaque psoriasis: up-to-date. Expert Opin Biol Ther. 2019; 19(4): 287-292.
2. Galluzzo M. et al. Spotlight on brodalumab in the treatment of plaque psoriasis: the evidence to date. Clin cosmet Investig Dermatol. 2019; 1(12): 311-321.
3. Papp K. et al. Safety and efficacy of brodalumab for psoriasis after 120 weeks of treatment. J Am Acad Dermatol. 2014; 71(6): 1183-1190.

Abbreviated Package Insert of LUMICEF® Solution For Injection In Pre-Filled Syringe 210mg/1.5ml

Indications: Psoriasis vulgaris that respond inadequately to existing therapies. Precautions related to indications: Administer to any of the following patients. 1. Patients who responded inadequately to phototherapies or other existing systemic therapies (except biologics) and who have skin eruptions over 10% or more of the body surface area. 2. Patients who have intractable skin eruptions. **Dosage and Administration:** Usually, for adults, administer subcutaneously 210 mg as brodalumab (genetical recombination) in the first dose, followed by doses at 1 week later, 2 weeks later, and once every 2 weeks thereafter. **Contraindications:** Patients with a serious infection; Patients with active tuberculosis; Patients with a history of hypersensitivity to any of the ingredients of LUMICEF®. **Precautions:** Patients with infections or suspected infections; Patients with a history of tuberculosis; Patients with depression; Patients with active Crohn's disease; Elderly patients. **Clinically significant adverse reactions:** Serious infection (0.8%); Neutrophil count decreased (0.7%); Serious hypersensitivity (0.02%). Approved version of package insert: Oct 2018.

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