THE HONG KONG SOCIETY OF DERMATOLOGY AND VENEREOLOGY
香港皮膚及性病學會

Annual Scientific Meeting 2021

12 September 2021 (Sunday)

Supporting Organization:

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THE HONG KONG SOCIETY FOR PAEDIATRIC DERMATOLOGY

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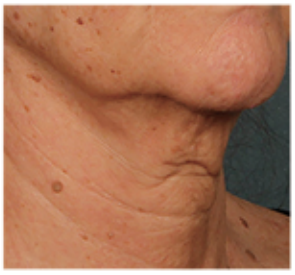
88% of patients were marked as significantly improved 12 weeks after a single treatment.[1]



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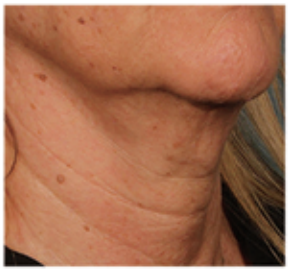
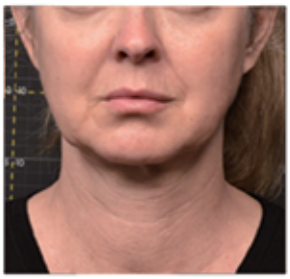


Single Treatment, 3 month FU

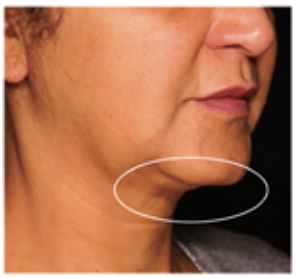
Courtesy of Arielle Kauvar, MD

Baseline



Single Treatment, 6 week FU

Courtesy of Gilly Munavalli, MD



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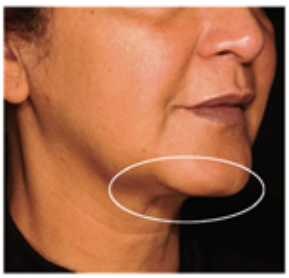
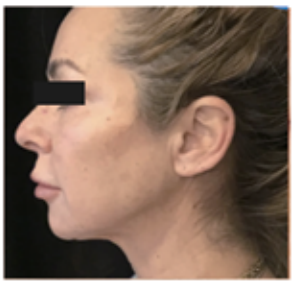


Single Treatment, 3 month FU

Courtesy of Roy Geronemus, MD

Baseline



Single Treatment, 2 month FU

Courtesy of Mona Foad, MD

[1] Data on file, patient results may vary

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More Information

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Welcome Message

Dear Colleagues,

Greetings to all of you and welcome to the Annual Scientific Meeting (ASM) of the Hong Kong Society of Dermatology and Venereology 2021.

Ever since the COVID-19 pandemic started in 2020, the challenges still remain this year. With the gathering and traveling restrictions continue to be in force locally, our ASM this year will again be arranged in virtual format. We will be live-streaming all sessions at the Sheraton Hotel and Towers Hong Kong via webcast while all the overseas speakers and participants will join in virtually.

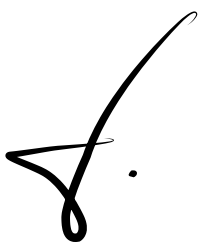
Paediatric dermatology is one of the major sessions of this year's meeting. We are honored to have Dr. David Orchard from Royal Children's Hospital, Melbourne, Australia to share his experience in paediatric psoriasis. We also have our local expert Dr. David Luk to talk about topical treatments of atopic dermatitis.

Hot topics in biologic therapy will be another main theme. Dr. Chih-ho Hong from Canada will share with us his views on treatment goals of psoriasis. Professor Peter van de Kerkhof from Netherlands and Dr. Yung Chan from Hong Kong will share their valuable experiences in biologics use in psoriasis. Professor Eric Simpson from USA and Dr. Chi-keung Yeung from Hong Kong will share their expertise in managing atopic dermatitis.

We will also have Professor Torsten Zuberbier from Germany to talk about treatments of urticaria. Furthermore, Professor Virginia Benitez Roig from Spain will show us her findings in the study of a new ultrasound device for face lifting.

We have three new young fellows for the New Fellow's Forum this year: Dr. Agnes Chan, Dr. Hing-wing Wong and Dr. Mandy Chan. They will share with us their interesting findings from their local studies. Last but not the least, interesting topics in sexually transmitted infections will be presented by local infectious disease expert Dr. Bonnie Wong and Dr. Kim-fung Cheng as well.

We sincerely hope all of you to find this year's ASM a fruitful and enjoyable experience. Hope we can meet each other in a face to face meeting soon.



Dr. Fong-cheng Ip
Chairman
The Hong Kong Society of Dermatology and Venereology

Dr. Mimi Chang
Chairman
The Hong Kong Society for Paediatric Dermatology

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Dr. Chi-keung YEUNG

Programme

09:00 – 09:05	**Opening Remarks** Dr. Fong-cheng IP Chairman, The Hong Kong Society of Dermatology and Venereology
09:05 – 09:50	**Symposium I: New Fellows' Forum** Chairpersons: Dr. Christina CHEUNG and Dr. Christina WONG **Anti-MDA5 Antibody Positive Dermatomyositis: A Review of Adult Patients in a Tertiary Centre in Hong Kong** Dr. Agnes CHAN (Hong Kong) **A Study on the Diagnostic Performance of Transient Elastography for Detection of Liver Fibrosis in Patients Receiving Methotrexate for Psoriasis** Dr. Hing-wing WONG (Hong Kong) **Assessing the Prevalence of Metabolic Syndrome in Adult Asian Patients with Atopic Dermatitis in a Tertiary Dermatology Centre in Hong Kong** Dr. Mandy CHAN (Hong Kong)
09:50 – 10:00	**Break**
10:00 – 11:15	**Symposium II: Paediatric Dermatology** Chairpersons: Dr. Fong-cheng IP and Dr. Chi-keung YEUNG **Practical Recommendations for the Topical Treatment of Atopic Dermatitis in South and East Asia** Dr. David LUK (Hong Kong) **Overview on Paediatric Psoriasis Management** Dr. David ORCHARD (Australia) **Clinical Experience with Biologics in Paediatric Psoriasis** Dr. David ORCHARD (Australia) **Q & A**
11:15 – 11:30	**Break**
11:30 – 12:45	**Symposium III: Update on Biologics in Atopic Dermatitis and Psoriasis** Chairpersons: Dr. Po-tak CHAN and Dr. Shun-chin NG **Real World Experience in Guselkumab Prescription in Psoriasis Treatment in Hong Kong Patients** Dr. Yung CHAN (Hong Kong) **The Emerging Treatment Paradigm for Atopic Dermatitis: What to Expect?** Professor Eric SIMPSON (USA) **Treat Psoriasis for the Long Haul: Findings on Ixekizumab from Clinical Trials** Professor Peter van de KERKHOF (The Netherlands) **Q & A**
12:45 – 13:50	**Lunch Break**
12:50 – 13:10	**Annual General Meeting**

13:50 – 14:30	**Lunch Symposium (sponsored by AbbVie Limited)** Chairperson: Dr. Tin-sik CHENG **Commit to Clear: Optimal Outcomes in Psoriasis** Dr. Chih-ho HONG (Canada) **Q & A**
14:30 – 14:40	**Break**
14:40 – 15:55	**Symposium IV: Update in Dermatology** Chairpersons: Dr. Mimi CHANG and Dr. Henry HO **Antihistamine Optimisation in the Treatment of Urticaria** Professor Torsten ZUBERBIER (Germany) **New Technology Optimization in Ultrasound Platform: The SUPERB Evolution** Professor Virginia BENITEZ ROIG (Spain) **Reach Beyond the Conventional in Managing Atopic Dermatitis** Dr. Chi-keung YEUNG (Hong Kong) **Q & A**
15:55 – 16:05	**Break**
16:05 – 16:55	**Symposium V: Sexually Transmitted Infections** Chairpersons: Dr. King-man HO & Dr. Fong-cheng IP **PrEP and Its Local Perspective** Dr. Bonnie WONG (Hong Kong) **Mycoplasma Genitalium: A New Challenge** Dr. Kim-fung CHENG (Hong Kong) **Q & A**
16:55 – 17:00	**Wrap Up** Dr. Fong-cheng IP Chairman, The Hong Kong Society of Dermatology and Venereology

Academic Accreditations

Organization	Points Accredited
Hong Kong College of Community Medicine	
The Hong Kong College of Family Physicians	5
Hong Kong College of Paediatricians	6
The Hong Kong College of Pathologists	6
Hong Kong College of Physicians	6
The College of Surgeons of Hong Kong	6
MCHK CME Programme	5

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Honorary Consultant, Matilda International Hospital, Hong Kong

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Professor Torsten ZUBERBIER
Head, Department of Dermatology and Allergy, Allergy Centre Charité, Charité – Universitätsmedizin Berlin, Germany

Anti-MDA5 Antibody Positive Dermatomyositis: A Review of Adult Patients in a Tertiary Centre in Hong Kong

Dr. Agnes CHAN
Assistant Professor, Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Hong Kong

Introduction

Anti-MDA5 antibody (Ab) has been reported to occur exclusively in patients with dermatomyositis. Patients with anti-MDA5 Ab have been reported to have specific characteristics including clinically amyopathic dermatomyositis (CADM), and increased mortality due to rapidly progressive lung disease (RP-ILD). Distinctive cutaneous features have been reported in anti-MDA5 Ab positive patients with clinical significance, as early diagnosis and prompt immunosuppressive treatment may aid to reduce mortality.

Objectives

We sought to examine clinical characteristics of anti-MDA5 Ab positive dermatomyositis patients and determine if they have specific cutaneous phenotype in a tertiary centre in Hong Kong. We also assessed and compared laboratory, histological, treatment and outcomes between anti-MDA5 Ab positive and negative patients.

Methods

This was a retrospective study. All adult patients diagnosed with dermatomyositis and on follow- up at the Prince of Wales Hospital between 1st January 2015 to 31st January 2020, with myositis autoantibody panel performed were included in the study.

Results

A total of 25/64 (39%) patients were positive for anti-MDA5 Ab. Anti-MDA5 was significantly associated with CADM, RP-ILD, pneumomediastinum, and lower cumulative 12-month survival rates. Patients presented with significantly more cutaneous manifestation of inverse Gottron's papules, periungual erythema, vasculitis, cutaneous ulceration, oral ulcers, and rashes on the ears.

Conclusion

Presence of anti-MDA5 Ab in patients with dermatomyositis was associated with significantly lower cumulative 12-month survival rates. Anti-MDA5 Ab positive patients have distinctive characteristic and cutaneous phenotype. It is imperative to be aware and vigilant of these cutaneous and clinical features due to risk of RP-ILD and significant mortality.

A Study on the Diagnostic Performance of Transient Elastography for Detection of Liver Fibrosis in Patients Receiving Methotrexate for Psoriasis

Dr. Hing-wing WONG

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

Long-term usage of methotrexate (MTX) is known to be associated with liver fibrosis. Percutaneous liver biopsy has been the gold standard test for liver fibrosis but it is associated with significant adverse effects.

Transient elastography (TE) is a non-invasive, ultrasound-based method to assess the liver stiffness. Previous studies on the performance of TE in non-Chinese patients with psoriasis on MTX showed high negative predictive value (ranged from 83.9% to 100%) and high specificity (ranged from 66.7% to 88%) for liver fibrosis. However, data regarding the diagnostic performance of TE in local patients with psoriasis is lacking.

Patients on long-term MTX for psoriasis were recruited from the nine Social Hygiene Clinics if the inclusion criteria were fulfilled. The recruited subjects then underwent liver biopsies and TE. The diagnostic performance of TE was assessed by comparison with liver biopsies. Association factors for liver fibrosis were identified by logistic regression analysis.

Results

Six out of 56 patients (10.7%) were diagnosed to have significant liver fibrosis by liver biopsies. The sensitivity, specificity, positive predictive value and negative predictive value of TE for significant liver fibrosis were 66.7%, 88.0%, 40.0% and 95.7% respectively. Abnormal fasting glucose level was independently associated with liver fibrosis.

Conclusion

MTX-induced liver fibrosis is uncommon. TE has an excellent negative predictive value for liver fibrosis. MTX may be safely continued in low-risk patients with normal TE result.

Assessing the Prevalence of Metabolic Syndrome in Adult Asian Patients with Atopic Dermatitis in a Tertiary Dermatology Centre in Hong Kong

Dr. Mandy CHAN

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

The association between atopic dermatitis (AD) and metabolic syndrome (MetS) is controversial. Recently, the association between chronic inflammatory skin diseases and metabolic syndrome (MetS) has garnered increasing attention. Some studies demonstrated a positive correlation, while others indicated that the association remained unclear. Given its controversial findings, further epidemiological studies are needed to investigate the association between AD and MetS. A review of AD and MetS is lacking in Hong Kong, and this study aimed to assess the prevalence of MetS in AD patients in a tertiary hospital.

Practical Recommendations for the Topical Treatment of Atopic Dermatitis in South and East Asia

Dr. David LUK
Consultant Paediatrician, United Christian Hospital & Hong Kong Children's Hospital, Hong Kong

Introduction

There is some evidence to suggest that the prevalence of atopic dermatitis (AD) in Asia is rising. We have therefore developed an algorithm for the topical treatment of AD throughout South and East Asia for use by primary care physicians, pediatricians and dermatologists.

Methods

Nine AD experts from South and East Asia and one from Europe developed the algorithm based upon treatment guidelines, relevant literature and local treatment practices. The algorithm outlines current best practice for the use of emollients, topical corticosteroids (TCS) and topical calcineurin inhibitors (TCI), with the intention of simplifying the treatment regimen of mild-to-moderate AD in South and East Asia.

Results

Patients with AD should bathe and cleanse affected skin to remove crusts and scales daily. Emollients should also be applied daily as a maintenance treatment. When selecting appropriate topical anti-inflammatory treatment for AD flares, several factors should be taken into consideration, including the patient's age, attitude to treatment options and site of AD lesions. Given the concerns regarding the risk of skin atrophy with use of TCS, a TCI should be used to treat AD lesions in sensitive skin areas: pimecrolimus is recommended for mild-to-moderate AD in these locations, while tacrolimus should be considered for moderate and severe cases. Either pimecrolimus or tacrolimus is recommended for flares in other, non-sensitive body locations. A proactive or intermittent maintenance treatment strategy involving regular emollient use and twice-weekly application of a TCI to previously affected areas is encouraged to reduce the risk of flares.

Conclusions

The algorithm proposed here is intended to simplify the topical treatment of mild-to-moderate AD in daily practice in South and East Asian countries.

Overview on Paediatric Psoriasis Management

Professor David ORCHARD
Director, Dermatology Department, The Royal Children's Hospital, Melbourne, Australia

Paediatric psoriasis is a common disorder with significant morbidity and 30-40% of adult cases begin by age 15. Considering a significant proportion of adult cases of psoriasis develops in children, it is important to diagnose and establish early management. Early intervention can maintain clearance, limit severity of the disease as well as reduce the psychological and emotional stress of this disease. Biologic modalities offer much promise for the efficacious and safe management of psoriasis in children. Presented in this lecture is an overview of the presentation of paediatric psoriasis as well as an up to date review of management options.

Clinical Experience with Biologics in Paediatric Psoriasis

Professor David ORCHARD
Director, Dermatology Department, The Royal Children's Hospital, Melbourne, Australia

In adults, biologics have revolutionized the treatment of moderate to severe plaque psoriasis and research on biologics has recently been extended to children. Treatment choice depends on the patient with consideration of comorbidities, impact on quality of life, and relevant safety aspects. Clinical cases will be presented and this talk will discuss a variety of strategies for improving outcomes of patients with paediatric psoriasis.

Real World Experience in Guselkumab Prescription in Psoriasis Treatment in Hong Kong Patients

Dr. Yung CHAN
Honorary Consultant, Matilda International Hospital, Hong Kong

Interleukin-23 (IL-23) is regarded as a master regulator of autoimmunity, representing an initiating cytokine in the upstream pathway of chronic tissue inflammation. This finding subsequently leads to the notion of developing IL-23 inhibitors as novel biologics for treating psoriasis. Guselkumab, a fully-human monoclonal antibody, is the first selective IL-23 inhibitor for the treatment of moderate-to-severe plaque psoriasis. It shows long-lasting effects and avoids adverse effects of blocking IL-17, including candida infections or inflammatory bowel disease.

Pivotal phase 3 trials indicated that PASI90 and PASI100 response rate of guselkumab was ~80% and ~50% at Week 48 respectively, and numerically greater proportions of patients treated with guselkumab achieved 90% and 100% improvements in various PASI components than those treated with secukinumab (an IL-17 inhibitor).

Comparing with IL-17 inhibitors, onset of action of IL-23 inhibitors appears to be longer. However, the ultimate goal of any psoriasis treatment is to achieve and maintain clear skin. Indeed, a pivotal placebo-controlled phase 3 trial demonstrated that over half of the patients receiving guselkumab achieved PASI100 response at Week 100, and this response rate was maintained up to Week 204. Guselkumab was considered well-tolerated at 5 years with no new safety signals being identified. No cases of Crohn's disease were found at 1 year and serious/Candida infections were detected in ≤2% of patients.

In this presentation, the Interleukin-23 inhibitors in clinical practice management of plaque psoriasis & Hong Kong real world data of Guselkumab will be discussed.

The Emerging Treatment Paradigm for Atopic Dermatitis: What to Expect?

Professor Eric SIMPSON
Professor of Dermatology and Director of Clinical Research, Oregon Health & Science University, Portland, USA

The classification of skin diseases and their treatment options are becoming more and more complex. While the morphology of diseased skin was prominent for disease classification and therapeutic procedures for quite a while, we now have the methodologies for a deep analysis of molecular processes and immunological pattern analysis responsible for the pathophysiological alterations. These advances enlarged our therapeutic repertoire in dermatology remarkably. It has been understood that the type 2 inflammatory response plays a critical role in atopic dermatitis (AD). Yet, the number of therapeutic options targeting this pathing is increasing. In the expanding landscape of AD treatment, what are the key issues we should be aware of? And what should a physician consider when choosing a treatment for the optimal outcome?

Treat Psoriasis for the Long Haul: Findings on Ixekizumab from Clinical Trials

Professor Peter van de KERKHOF
Senior Professor, Department of Dermatology, Radboud University Nijmegen Medical Centre, The Netherlands
Chief Medical Officer, International Psoriasis Council, St. Louis, USA

Pathogenesis based treatments have enriched the treatment possibilities for psoriasis profoundly. Sustainable long-term disease control has become possible for the majority of patients. The understanding of the impact of IL-17 in the pathogenesis of psoriasis has been a major contribution to the innovation of the treatment of psoriasis, anti IL-17 treatments have made possible what was not possible before.

The IL-17 pathway is a key pathway in the pathogenesis of psoriasis. IL-17 is released by a host of immunocytes, some of these dependent on IL-23 stimulations and some of these independent from IL-23. IL-17 signalling has been shown to be a major component of systemic inflammation in patients with psoriasis, having an impact on arthritis and atherosclerosis.

Psoriasis and comorbidity is not just a statistical association. It is relevant in our daily practice. In particular, early recognition of arthritis, management of psoriasis as independent risk factor for cardiovascular disease and recognition of depression are responsibilities for the dermatologist.

Anti-Il-17 treatments permit clear skin in half of the patients and studies show that the improvements are sustainable. In this presentation the results of ixekizumab will be presented, showing (1) the fast onset of improvement, (2) clear skin in about half of the patients (3) the durability of the response (4) the effect of Ixekizumab on psoriatic arthritis.

The safety of ixekizumab is based on a large collective of clinical trials. Overall ixekizumab has an outstanding safety profile. A slight increase in upper respiratory infection, injection sit reaction, reactivation of inflammatory bowel disease and candidiasis have been reported.

In daily practice ixekizumab is an outstanding treatment with high clearing capacity, sustained treatment response and fast onset of action with an outstanding long-term safety.

Commit to Clear: Optimal Outcomes in Psoriasis

Dr. Chih-ho HONG

Clinical Assistant Professor, Department of Dermatology and Skin Science, University of British Columbia, Canada

The availability of targeted biologics such as IL-17 and IL-23 inhibitors has revolutionized the management of psoriasis in recent years. Many guidelines around the world are now suggesting a treatment goal of “clear” or “almost clear” skin. Early intervention achieving a highly patient centric target may cause less impact on the Cumulative Life Course Impairment (CLCI). It is commonly known that psoriasis significantly impacts patients physically, emotionally, and socially. The burden of living with the disease is now being assessed cumulatively along with coping strategies and external factors resulting in lifetime impairment. Dermatologists, therefore, have an important role to minimize the impact of psoriasis over the life course of patients. In this session, Dr. Chih-Ho Hong will bring together recent research on CLCI, the importance of achieving high treatment goals, as well as the latest data in psoriasis management illustrated through case studies.

Antihistamine Optimisation in the Treatment of Urticaria

Professor Torsten ZUBERBIER
Head, Department of Dermatology and Allergy, Allergy Centre Charité, Charité – Universitätsmedizin Berlin, Germany

According to the 2020 update of the international guidelines and the new classification, chronic urticaria is defined by the sudden appearance of wheals, angioedema or both, lasting for at least six weeks. Chronic urticaria comprises chronic spontaneous urticaria, where wheals appear without any external stimulus, and the chronic inducible urticaria subtypes, e.g. cold urticaria which is also chronic but only shows symptoms when the stimulus is present.

The evidence based treatment of chronic urticaria in general is based on the principles of ideally identifying and avoiding the trigger of the disease, e.g. in chronic spontaneous urticaria gastritis or sinusitis or avoidance of eliciting drugs, mainly NSAIDs, but many cases need symptomatic treatment.

For symptomatic treatment the guidelines provide an evidence-based algorithm. First-line therapy are modern second-generation antihistamines which should be increased in dosage in second line, if required up to fourfold. Sedating first-generation antihistamines should be avoided as well as the use of systemic corticosteroids. For patients who are nonresponders or partial responders in the next steps and add on treatment with omalizumab or if that fails cyclosporin A is foreseen. Most importantly however the new update of the guidelines clearly recommends to continuously assess and adjust treatment. Regarding antihistamines only those which are truly nonsedating should be used and can be used in the flexible way, especially in inducible urticaria and optimized patient centered approach can be advised. As an example, in a patient with cholinergic urticaria a basic treatment of 20mg bilastine od in the morning could be sufficient to block symptoms for normal activities at office work but on weekends when this patient knows he is going to play soccer he is advised to increase the dose to 40 or 80 mg in the morning.

New Technology Optimization in Ultrasound Platform: The SUPERB Evolution

Dr. Virginia BENITEZ ROIG
Director, Laser Department, Helicopteros Sanitarios Hospital, Marbella, Spain

Background

Ultrasound technology can treat fine lines and wrinkles as well as lift lax skin. Although early technology was less than optimal, a new-generation device (Sofwave, Yokneam, Israel) can safely target the mid-dermis to maximize neocollagenesis and neoelastogenesis, while incorporating feedback-controlled skin cooling and energy deposition. This ultrasound device utilizes synchronous ultrasound parallel beams to deliver seven beams of thermal energy at once to the mid-dermis at 1.5mm, increasing tissue temperatures to 60-70 degrees Celsius.

Study Design

A prospective, multi-center, clinical study investigated the utility of this new-generation ultrasound device to lift lax skin of the eyebrow and submentum. 60 subjects were enrolled to receive single treatment to entire face and neck, which included darker skin types. Measurements at baseline and 12-week follow-up were used to calculate eyebrow and submental lifting as post-hoc analysis.

Results

58 subjected completed the study. Two blinded reviewers were in agreement in identifying the pre- and post-treatment photographs correctly for 78% of subjects. There was improvement of 1-3 Elastosis Score units in 86% of subjects using Fitzpatrick Wrinkle and Elastosis Scale for perioral and periorbital regions. Overall, 72% of subjects noted improvement in wrinkle appearance, and majority were satisfied. There were no device-related adverse events and no downtime with all subjects.

For the post-hoc analysis of lifting, photographs of 32 and 35 subjects were evaluable for eyebrow and submental measurements, respectively. 94% of subjects had an increase in both the average and the maximal eyebrow heights above the prespecified threshold of 0.5mm in either right eyebrow, left eyebrow, or both. Mean change in average eyebrow height was 1.4mm and the mean change of maximal eyebrow height was 1.6mm. 83% of subjects had a reduction in submental area above the prespecified threshold of 20mm2. Average submental lift was 89.2mm2.

Conclusion

This new-generation ultrasound device was demonstrated to safely provide clinical lifting of lax skin of the eyebrow and submentum after a single treatment.

Reach Beyond the Conventional in Managing Atopic Dermatitis

Dr. Chi-keung Yeung
Honorary Clinical Associate Professor, Division of Dermatology, Department of Medicine, The University of Hong Kong, Hong Kong

Atopic Dermatitis (AD) is associated with signs and symptoms that heavily impact patients' daily lives especially in itch, sleep disturbance and skin pain. We will have a closer look on Baricitinib in this lecture, the first approved JAK inhibitor for moderate to severe AD, how could it potentially close the gap in fulfilling patient's unmet need in this evolving era of AD Management.

PrEP and Its Local Perspective

Dr. Bonnie WONG
Senior Medical Officer, Special Preventive Programme, Centre for Health Protection, Department of Health, Hong Kong

PrEP, or pre-exposure prophylaxis, is an additional option for HIV prevention recommended by the World Health Organization (WHO) for individuals at substantial risk of HIV acquisition. Its success would rely not only on one's adherence with the regimen, but also on a multitude of factors to define the best delivery model that suits the needs of the local community. This talk will cover the landmark trials on PrEP, the barriers and challenges of PrEP delivery, the current landscape on its use locally and in other major cities, and the constructs of healthcare accessibility. It will also highlight the importance of the provision of a bundle of healthcare interventions that should be offered, at the same time, to clients seeking PrEP.

Mycoplasma Genitalium: A New Challenge

Dr. Kim-fung CHENG
Medical Officer, Social Hygiene Service, Department of Health, Hong Kong

Mycoplasma species was first discovered about 120 years ago and Mycoplasma genitalium (MG) was first described in the literature in early 1980s, as being isolated from 2 patients presented with NGU. Many recent studies, however, have shown that MG is now a common sexually transmitted infection (STI).

Studies in the association between MG and NGU have been remarkably consistent. And it has an even stronger association with non-chlamydial NGU (NCNGU). Despite initial contradictory findings regarding the association between MG and female genital tract pathology, several recent studies have since confirmed this association. A meta-analysis has shown there is a 2-fold increased risk of cervicitis, PID, preterm delivery & spontaneous abortion for women with MG infection. Yet an association with infertility remains to be defined.

Up-to-date, nucleic acid amplification tests (NAT) are regarded as the standard of diagnosis. First void urine was found to be the most sensitive and patient-friendly test for MG detection in male patient. For female patient, some studies have shown that vulvovaginal swab was the most sensitive specimen for MG detection. Nevertheless, MG test is only recommended in clinically indicated conditions and not for routine STI screening.

The main challenge to treatment is the ever rising rate of the anti-microbial resistance (AMR) MG strains. Macrolide resistant is common in Hong Kong and many parts of the world. The rate of fluoroquinolone resistant is rising and becoming a problem. For uncomplicated MG infection, most guidelines suggest the sequential therapy with doxycycline and extended course of azithromycin, and moxifloxacin will be reserved for the failing cases. For complicated MG infection, moxifloxacin (with or without doxycycline) will be the choice of first line treatment.

In gist, MG is one of the major curable causes of STI worldwide, although it is an uncommon STI in the general population. It is common among NGU and NCNGU patients. Some patients acquired MG is asymptomatic and may not develop disease. However, infection in women may cause adverse female genital tract complication. With the development of multi-drug resistant MG infection in HK and globally, it will definitely be a challenge to the future management of MG infection.

Acknowledgements

The Council of the Hong Kong Society of Dermatology and Venereology would like to extend their heartfelt thanks to the following sponsors for the supports to the meeting.

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Labixten®: A LIFETIME COMPANION FOR THE TREATMENT OF ALLERGIES[1,2]

LABIXTEN®
bilastine

The first antihistamine in orodispersible tablet (ODT) form for children in Hong Kong[3]

- Symptomatic treatment of **allergic rhinoconjunctivitis** (seasonal and perennial) and **urticaria** for children 6–11 years with a body weight of at least 20 kg.[1]
- Convenient and simple once daily **melt in mouth tablet** dosing and patient friendly **red grape flavour**.[1]
- Placebo-like tolerability profile including **lack of sedation / sleepiness** in children.[4]

Abridged Prescribing Information: LABIXTEN 10 mg Orodispersible Tablets
Indications: Symptomatic treatment of allergic rhino-conjunctivitis (seasonal and perennial) and urticaria. **Dosage and administration:** Children (6-11 years of age with a body weight of at least 20 kg): 10 mg once daily, 1 hour before or 2 hours after intake of food or fruit juice. **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. **Precautions:** Efficacy and safety of bilastine in children under 2 years of age have not been established and there is little clinical experience in children aged 2 to 5 years, therefore bilastine should not be used in these age groups. There is little experience in patients above the age of 65. Avoid coadministration of bilastine and P-glycoprotein inhibitors in patients with moderate or severe renal impairment. Caution in interaction with food, grapefruit juice, ketoconazole/erythromycin and diltiazem. As there are no or limited amount of pregnancy data, it is preferable to avoid use during pregnancy as a precautionary measure. **Undesirable effects:** Most commonly reported adverse reactions (ADRs) during clinical trials: headache, somnolence, dizziness, and fatigue. Common ADRs reported: Somnolence; headache. Uncommon ADRs reported: Oral herpes; increased appetite; anxiety; insomnia; tinnitus; vertigo; right bundle branch block; sinus arrhythmia; ECG abnormalities; dizziness; dyspnoea; nasal discomfort; nasal dryness; upper abdominal pain; abdominal pain; nausea; stomach discomfort; diarrhoea; dry mouth; dyspesia; gastritis; fatigue; thirst; pyrexia; asthenia. [Jun 2020]. **For further information consult full prescribing information.**

References: 1. Labixten® 10 mg ODT HK PI (Oct 2018). **2.** Church MK, Tiongco-Recto M, Ridolo E, Novak Z. *Bilastine*: a lifetime companion for the treatment of allergies, Current Medical Research and Opinion 2020;36(3):445-454., DOI:10.1080/03007995.2019.1681134. **3.** Drug Office I 藥物辦公室 [Internet]. Hong Kong: Department of Health; c2020 [updated 18 Sep 2020]. Available from: https://www.drugoffice.gov-.hk/eps/do/en/consumer/search_drug_database.html by searching "orodispersible". Accessed on: 18 Sep 2020. **4.** Novák Z, Yáñez A, Kiss I, *et al*. Safety and tolerability of bilastine 10 mg administered for 12 weeks in children with allergic diseases. *Pediatr Allergy Immunol*. 2016;27(5):493-8.

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

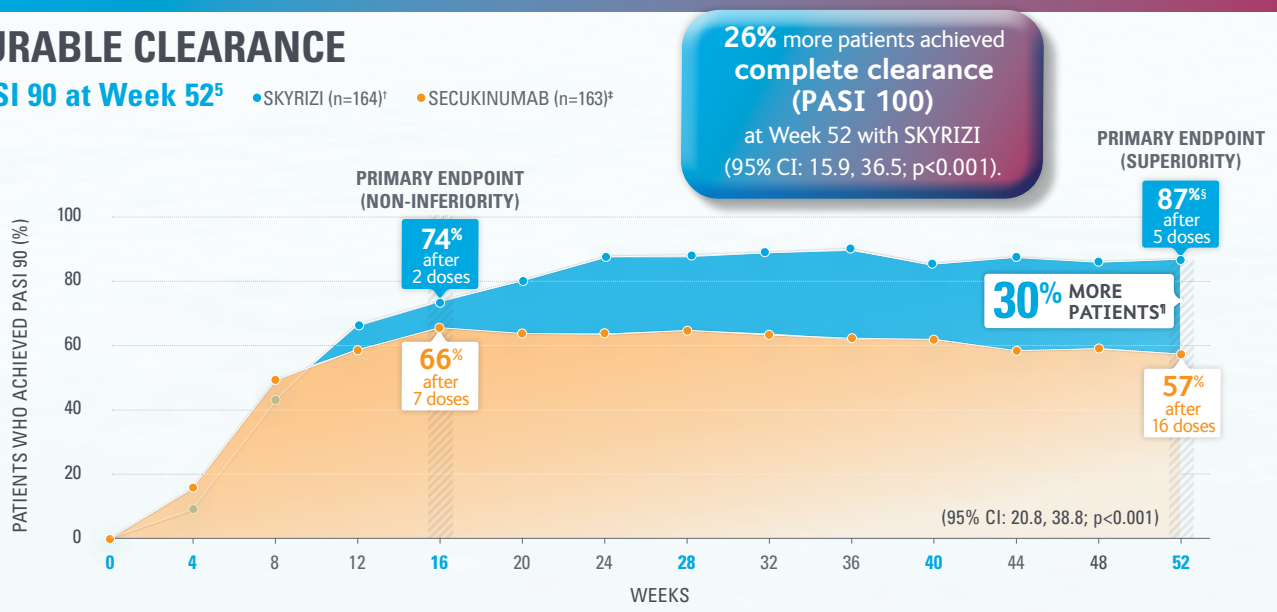
NOTHING IS EVERYTHING

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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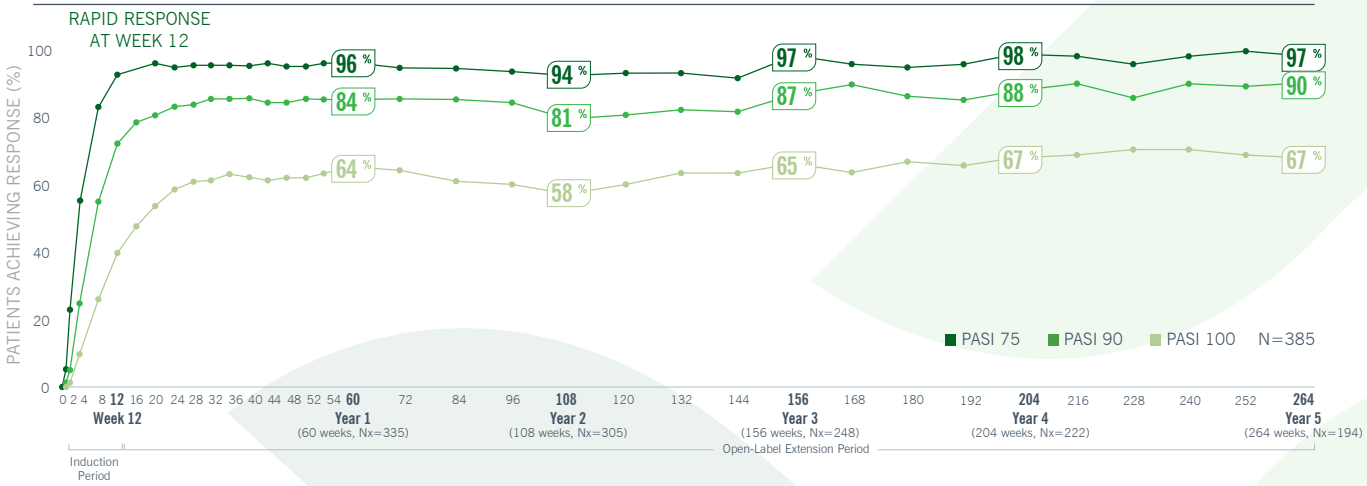
Sustained skin clearance over 5 years of treatment[1]

Nearly 7 out of 10 patients achieved or maintained PASI 100 through week 264

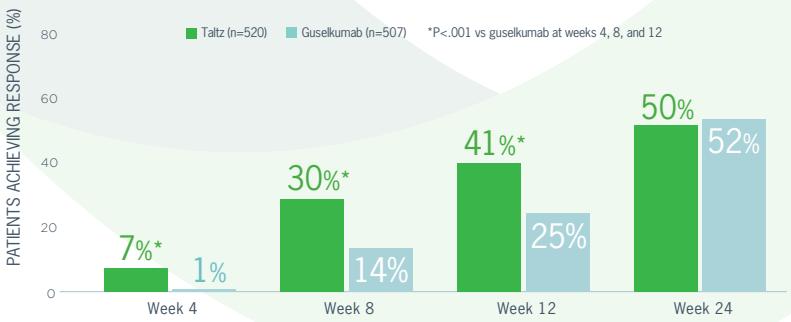
UNCOVER-3: PASI 75, PASI 90, AND PASI 100 OBSERVED RESULTS AT WEEKS 12, 60, 108, 156, 204 AND 264[1,2]



Complete, superior and rapid clearance[3,4]

Taltz was superior to guselkumab in providing complete skin clearance (PASI 100) at weeks 4, 8, and 12

IXORA-R: PERCENTAGE OF PATIENTS ACHIEVING PASI 100 AT WEEKS 4, 8, 12, AND 24, NRI[3,4]



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

References

1. Blauvelt A, et al. Long-term efficacy and safety of ixekizumab: A 5-year analysis of the UNCOVER-3 randomized controlled trial [published online ahead of print, 2020 Nov 28]. J Am Acad Dermatol. 2020;S0190-9622(20)33053-X. **2.** Lebwohl MG, et al. Ixekizumab sustains high level of efficacy and favourable safety profile over 4 years in patients with moderate psoriasis: results from UNCOVER-3 study. J Eur Acad Dermatol Venereol. 2020;34:301-309. **3.** Data on file [t_pasi_resp_nri_itt_db]. Eli Lily and Company; 2020. **4.** Blauvelt A, et al. A head-to-head comparison of ixekizumab vs. guselkumab in patients with moderate-to-severe plaque psoriasis: 12-week efficacy, safety and speed of response from a randomized, double-blinded trial. Br J Dermatol. 2020;182:1348-1358.

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-0169 06/2021

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The **FIRST** JAK inhibitor indicated for adult AD patients who are uncontrolled on topicals alone.[1]

Olumiant in combination with TCS decreased ITCH **as early as DAY 2**[2*†]

Consider a once-daily oral medication for those patients whose lives are still impacted by AD.

OLUMIANT® (baricitinib) Abbreviated Prescribing Information
Therapeutic indications: Rheumatoid Arthritis: OLUMIANT is indicated for the treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs. OLUMIANT may be used as monotherapy or in combination with methotrexate. Atopic Dermatitis: OLUMIANT is indicated for the treatment of moderate to severe atopic dermatitis in adult patients who are candidates for systemic therapy. **Recommended dose:** The recommended dose of OLUMIANT is 4 mg once daily. A dose of 2 mg once daily is appropriate for patients such as those aged ≥ 75 years and may be appropriate for patients with a history of chronic or recurrent infections. A dose of 2 mg once daily may also be considered for patients who have achieved sustained control of disease activity with 4 mg once daily and are eligible for dose tapering. **Contraindications:** Known hypersensitivity to the baricitinib or any of the excipients. Pregnancy. **Special precaution:** Caution in patients with chronic, active or recurrent infections, monitor if infection develops; interrupt if not responding to treatment. Screen for tuberculosis, do not give if active; treat first if latent. Avoid or interrupt OLUMIANT with abnormal blood cell levels, lipids and liver enzymes. Use with live vaccines not recommended. The risk of malignancies including lymphoma is increased in patients with rheumatoid arthritis, OLUMIANT clinical data are insufficient to assess potential incidence of malignancies. Caution in patients with risk factors for deep venous thrombosis or pulmonary embolism, consider VTE prophylaxis. Use with bDMARD or other JAK is not recommended. Caution in patients with diverticular disease and especially in patients chronically treated with concomitant medications associated with an increased risk of diverticulitis. **Adverse reaction:** Very common: upper respiratory tract infections, hypercholesterolaemia. Common: herpes zoster, herpes simplex, gastroenteritis, urinary tract infections, pneumonia, thrombocytosis, headache, nausea, abdominal pain, elevation of alanine Transaminase and creatine phosphokinase , rash and acne. **Drug interaction:** Combination with biologic DMARDs or other JAK inhibitors has not been studied. Use of baricitinib with potent immunosuppressive medicinal products such as azathioprine, tacrolimus, or ciclosporin was limited in clinical studies of baricitinib, and a risk of additive immunosuppression cannot be excluded. Please refer to full prescribing information for further details. EUSPC20NOV2020

*1 day after initiating Olumiant; † Daily data were taken from patient diaries. The percent change from baseline in Itch NRS at 2 days was another secondary endpoint that was prespecified but not adjusted for multiplicity.

References: 1. Hong Kong Olumiant Prescribing Information. **2.** JAMA Dermatol. 2020;156(12):1333-1343.

Please see Important Safety Information in the full prescribing Information.

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Reference:
1. Layton AM, et al. Clin Exp Dermatol 1994;19(4):303–308. 2. Tan J, et al. J Drugs Dermatol 2017;16(2):97–102. 3. Chuah SY and Goh CL. J Cutan Aesthet Surg 2015;8(3):153–158. 4. Dunn LK, et al. Dermatol Online J 2011;17(1):1. 5. Hazarika N and Archana M. Indian J Dermatol 2016;61(5):515–520. 6. Loss M, et al. Dermatol Ther (Heidelb). 2018. https://doi.org/10.1007/s13555-018-0231-8. 7. Zaenglein AL, et al. J Am Acad Dermatol 2016;74:945-73. 8. Stein Gold L, et al. Am J Clin Dermatol 2016; 17: 293–303. 9. Dréno B, et al. Am J Clin Dermatol 2018; 19(2): 275–286.

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Triumph over Plaque Psoriasis with just One-PRESS

Complete skin clearance (PASI=0) maintained over 3 years[1*]

50% achievement of complete skin clearance by 16 weeks[1†]

99% patient satisfaction with Tremfya® One-Press patient-controlled injector[2‡]

* 22.7% (112/494) of patients treated with Tremfya® from Week 0/Week 16 maintained PASI=0 over 3 years.
† 50% of patients who maintained PASI=0 for ≥156 consecutive weeks achieved complete skin clearance by Week 16.
‡ 99% (68/69) of patients were satisfied/very satisfied with One-Press at Week 28.

Study design
In this post hoc analysis of 5-year data from the VOYAGE 1 trial, Patients with moderate-to-severe psoriasis who maintained PASI=0 at all visits for ≥156 consecutive weeks of Tremfya® treatment (n=112) were compared with patients who never achieved PASI=0 at any visit (n=79)[1].
This Phase 3, multi-center, double-blind, placebo-controlled study (ORION) randomized 78 adults with moderate-to-severe psoriasis (4:1) to self-inject Tremfya® 100 mg at Weeks 0/4/12/20/28 or placebo at Weeks 0/4/12 with crossover to self-inject Tremfya® 100 mg at Weeks 16/20/28[2].

Tremfya® solution for injection in pre-filled pen 100 mg/1 mL
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: Serious hypersensitivity reactions have been reported in the post-marketing setting. Some cases occurred several days after treatment with guselkumab, including cases with urticaria and dyspnoea. 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, or abstain from initiating treatment with 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 Pre-filled Pen aPI ver 1.0

References
1. Costanzo A, Conrad C, Gramiccia T, et al. Maintenance of Complete skin clearance throughout 3 years of continuous guselkumab treatment in patients with moderate-to-severe psoriasis: a post hoc analysis of 5-year data from the VOYAGE 1 trial. Poster 26581. American Academy of Dermatology's Virtual Meeting Experience, 23-25 April 2021.
2. Ferris LK, Ott E, Jiang J, et al. Efficacy and safety of guselkumab, administered with a novel patient-controlled injector (One-Press), for moderate-to-severe psoriasis: results from the phase 3 ORION study. J Dermatolog Treat 2020;31:152-159.

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- 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®, 200mg (n = 43; baseline weight <60 kg), or DUPIXENT®, 300mg (n = 39; baseline weight ≥60 kg), every 2 weeks; DUPIXENT®, 300mg, 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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Cosentyx®
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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 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).

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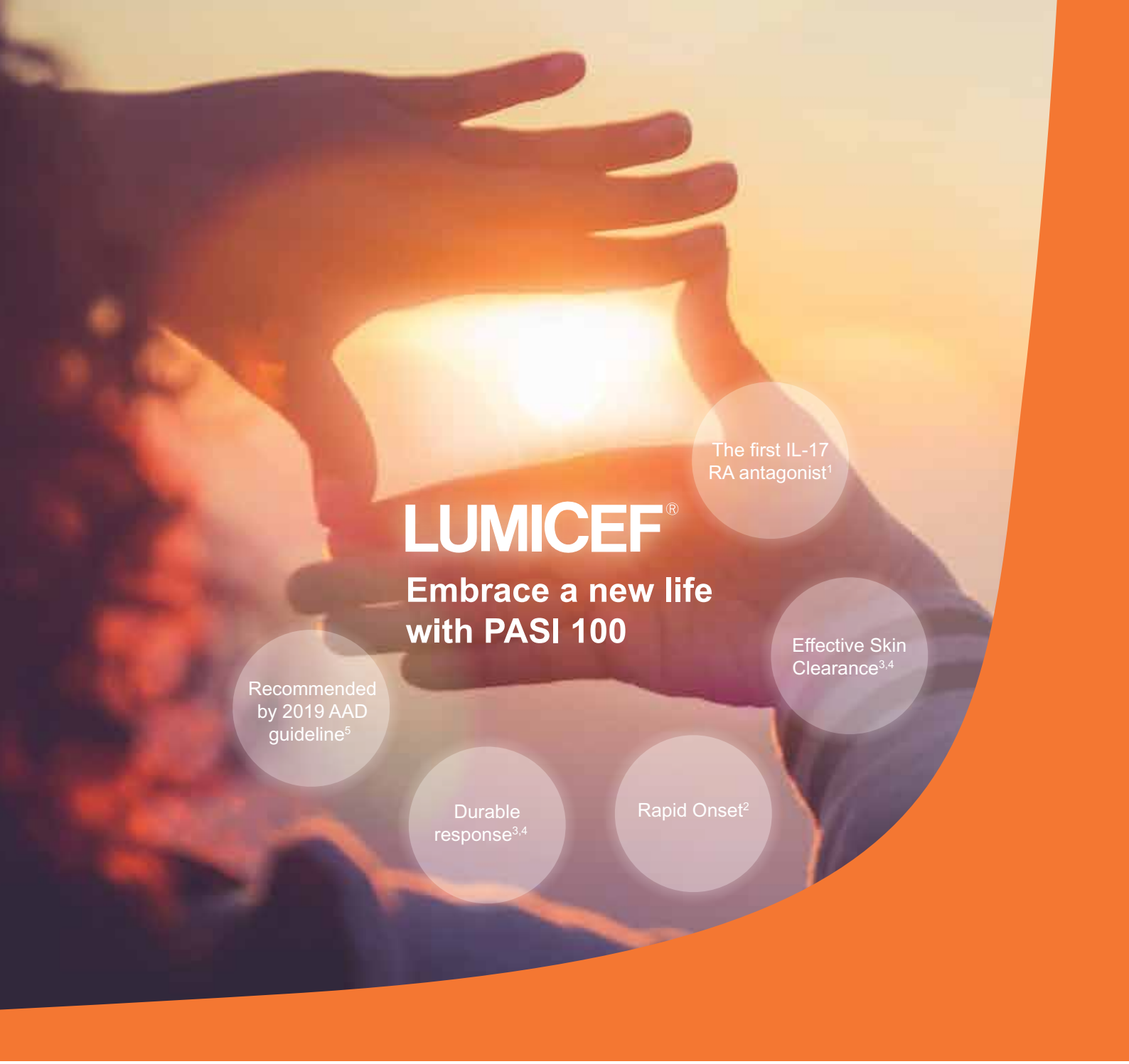

LUMICEF® 210mg

Brodalumab (genetical recombination) drug product

PASI: Psoriasis area and severity index

References: 1. Puig L. Drugs Today (Barc.). 2017;53:283-297. 2. Yao MPH, et al. J Drugs Dermatol. 2019;18:229-233. 3. Blauvelt A, et al. J Am Acad Dermatol. 2017;77:372-374.4. Lebwohl MG, et al. Am J Clin Dermatol. 2019;20:863-871. 5. Menter A, et al. J Am Dermatol. 2019;80:1029-1072.

LUMICEF® Abbreviated Prescribing Information
Composition: Brodalumab. **Indications:** Psoriasis vulgaris that respond inadequately to existing therapies.**Precautions related to indications:** Administer to any of the following patients: i) 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; ii) patients who have intractable skin eruptions. **Dosage and Administration:** <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:** Serious infection, active tuberculosis, history of hypersensitivity to any of the ingredients of Lumicef. **Precautions:** Infections or suspected infections, history of tuberculosis, depression or with such a history, history of suicidal ideation or suicidal attempt, active Crohn's disease, pregnancy & lactation, children, elderly, malignant tumors, avoid live vaccines, avoid other biologics. **Clinically significant adverse reactions:** Serious infection, neutrophil count decreased, serious hypersensitivity. **P/P:** Inj (pre-filled syringe): 210 mg /1.5 mL Approved version of package insert: Oct 2018.
Please refer to the full prescribing information before prescribing. Further information is available upon request.
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