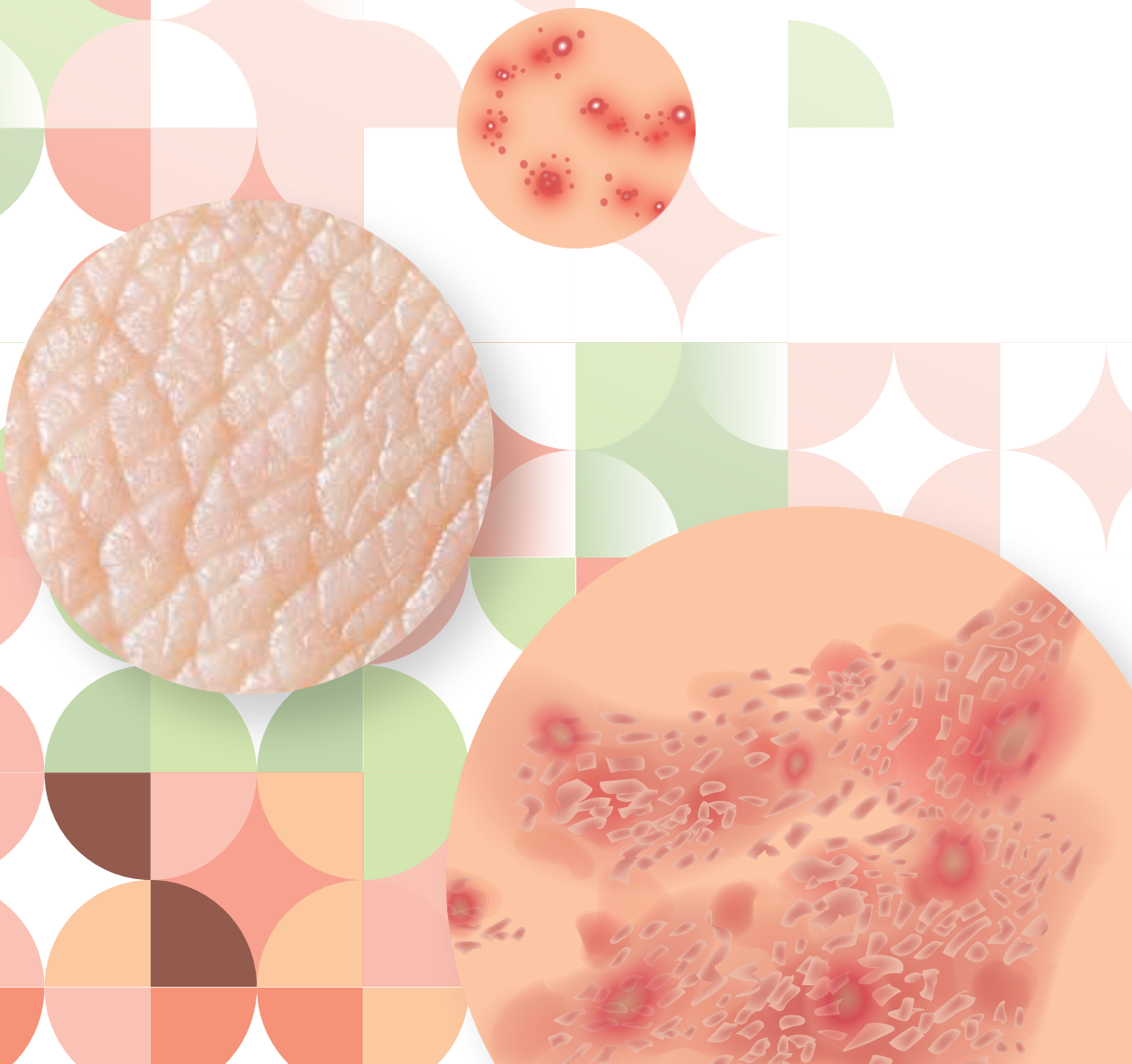
HKCD
HONG KONG COLLEGE OF DERMATOLOGISTS
香港皮膚科醫學院

HKSPD
THE HONG KONG SOCIETY FOR PAEDIATRIC DERMATOLOGY

# HKCD & HKSPD

## Joint Annual Scientific Meeting 2021

## 5 December 2021 (Sunday)



Skyrizi™ (risankizumab)

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

# NOTHING IS EVERYTHING

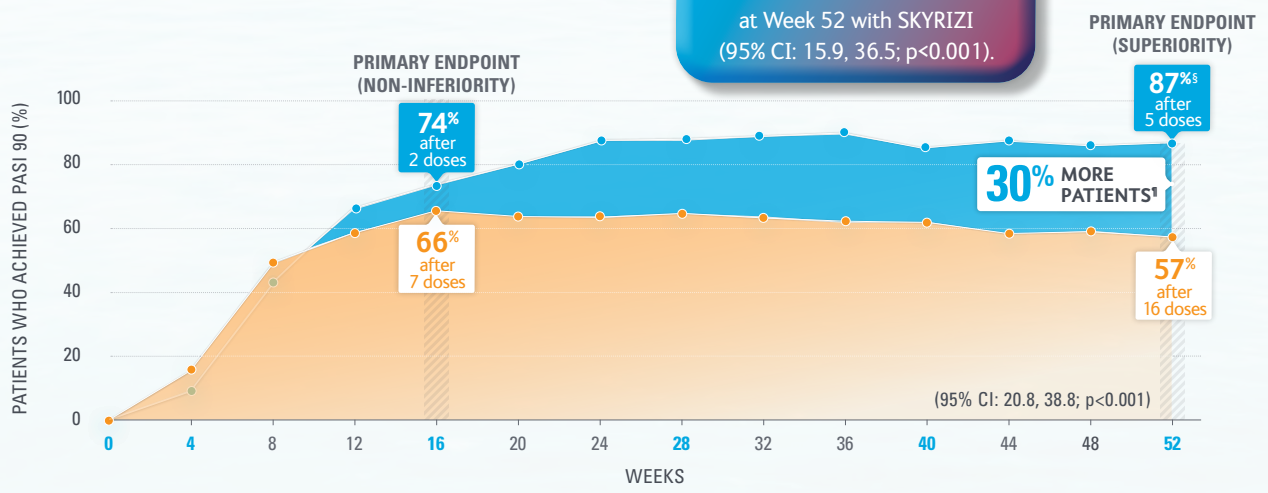
New IMMerge head-to-head data:

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

## DURABLE CLEARANCE

**PASI 90 at Week 52**[5] •SKYRIZI (n=164)† •SECUKINUMAB (n=163)‡

**26%** more patients achieved **complete clearance (PASI 100)** at Week 52 with SKYRIZI (95% CI: 15.9, 36.5; p<0.001).




†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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# Welcome Message

Dear Colleagues,

In the first quarter of this year we were forced to commit ourselves on whether our joint annual scientific meeting with the Hong Kong Society for Paediatric Dermatology would be in virtual form as 2020. Because of the big difference in venue cost the Council decided that, to be on the safe side, we would hold another virtual event. Hopefully, in 2022, we will be back with in-person meetings.

However, the quality of the symposia and state-of-the-art lecture is no less powerful and informative than that of past years'. Apart from local speakers, we are having distinguished presenters from three more continents - Australia, North America and Europe! Although the emphasis will again be on atopic dermatitis and psoriasis, there is a lecture on picosecond laser and future energy based devices by none other than Hong Kong's foremost expert - Professor Henry CHAN. I am sure you will all find this exciting and stimulating.

The presentations on atopic dermatitis and psoriasis include further elucidations of the pathogenesis and new developments on treatment modalities.

Looking forward to welcoming you all virtually I also wish to express my sincere thanks to the sponsors for their generous and continuous support.

**Dr. Sze-kee LEUNG**
President
Hong Kong College of Dermatologists

# Welcome Message

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 2021, jointly organized by the HKSPD and the Hong Kong College of Dermatologists.

With the on-going COVID-19 pandemic, vaccinations and activities reset to the new normal, we are happy to provide our virtual meeting as a platform for sharing of experience, expertise and collaboration for doctors with interest in pediatric skin diseases. We have more information and data regarding novel topical and systemic therapeutic options in management of common inflammatory dermatosis. We are very pleased to have distinguished speakers from across the world to enlighten us on such topics.

Last but not least, I would like to thank our council members, sponsors and participants for the continued support. Enjoy the meeting and don't hesitate to send us questions or comments in the Q and A session!

**Dr. Mimi Mee Chang**
President
The Hong Kong Society for Paediatric Dermatology

## Council of Hong Kong College of Dermatologists

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# Academic Accreditations

| Organization | Points Accredited |
|---|---|
| Hong Kong College of Community Medicine | **4** |
| The Hong Kong College of Family Physicians | **3** |
| Hong Kong College of Paediatricians (Category A) | **4** |
| The Hong Kong College of Pathologists | **TBC** |
| Hong Kong College of Physicians | **TBC** |
| The College of Surgeons of Hong Kong | **6** |
| MCHK Programme | **4.5** |

# Faculty

### Professor Henry CHAN
Honorary Clinical Professor and Honorary Consultant Dermatologist, 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

### Dr. Mimi CHANG
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

### Dr. Christina CHEUNG
Associate Consultant, Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong

### Dr. Seemal DESAI
Diplomate of the American Board of Dermatology, USA

### Professor Peter FOLEY
Associate Professor, Department of Medicine, The University of Melbourne, Australia

### Dr. William FUNG
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

### Dr. King-man HO
Specialist in Dermatology and Venereology, Hong Kong

### Professor Alan IRVINE
Professor of Dermatology (Clinical Medicine), Trinity College Dublin, Ireland

### Dr. Sze-kee LEUNG
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

### Dr. Kuen-kong LO
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### Professor Giovanni PELLACANI
Professor, Department of Dermatology, University of Modena and Reggio Emilia, Italy

### Professor Diamant THACI
Director and Full University Professor, Institute and Comprehensive Center Inflammation Medicine, University of Lübeck, Germany

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

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

# Programme

| | |
|---|---|
| 10:00 – 10:05 | **Welcome Remarks by HKCD President & HKSPD President** |
| 10:05 – 11:15 | **Symposium I**<br>Chairmen: Dr. Mimi CHANG & Dr. Sze-kee LEUNG<br><br>**Picosecond Laser in Dermatology and Future Energy Based Devices**<br>Professor Henry CHAN (Hong Kong)<br><br>**The Importance of Achieving Complete Skin Clearance that Lasts**<br>Dr. Yung CHAN (Hong Kong)<br><br>**Multidisciplinary Approach in Psoriatic Disease's Management**<br>Dr. Christina WONG (Hong Kong)<br><br>**Q&A** |
| 11:15 – 11:30 | **Break** |
| 11:30 – 12:45 | **Symposium II**<br>Chairmen: Dr. William FUNG & Dr. Kuen-kong LO<br><br>**Everyday Decision Making on Biologic Use for Psoriasis Patients**<br>Professor Peter FOLEY (Australia)<br><br>**Atopic Dermatitis: Hope is on the Horizon**<br>Professor Peter FOLEY (Australia)<br><br>**Updated Dermatitis Management Targeting Oxidative Stress**<br>Professor Giovanni PELLACANI (Italy)<br><br>**Q&A** |
| 12:45 – 14:10 | **Lunch Break** |
| 12:50 – 13:20 | **AGMs** |
| 14:10 – 14:45 | **State-of-the-Art Lecture (sponsored by Pfizer Corporation Hong Kong Limited)**<br>Chairman: Dr. King-man HO<br><br>**Deep Dive into Pathogenesis of Atopic Dermatitis and Recent Treatment Advances**<br>Dr. Seemal DESAI (USA) |
| 14:45 – 15:00 | **Break** |
| 15:00 – 16:15 | **Symposium III**<br>Chairmen: Dr. Christina CHEUNG & Dr. Chi-keung YEUNG<br><br>**Latest Treatment Advanced with IL-23 as Target for Psoriasis**<br>Professor Diamant THACI (Germany)<br><br>**Treating Eczema in Patients with Fragile Skin**<br>Professor Diamant THACI (Germany)<br><br>**New Treatment Strategies for Paediatric Patients with Atopic Dermatitis**<br>Professor Alan IRVINE (Ireland)<br><br>**Q&A** |

# Synopsis

Symposium I

## Picosecond Laser in Dermatology and Future Energy Based Devices

**Professor Henry CHAN**

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

Picosecond lasers with a much shorter pulse duration than nanosecond lasers are considered to generate more photomechanical effect and less photothermal and in doing so, reduce potential complication including post-inflammatory hyperpigmentation and texture changes. Picosecond lasers were first used for the treatment of tattoo but has since gained much popularity in the treatment of a wide range of pigmentary conditions including freckle, lentigo and nevus of Ota. Conditions that is less responsive include melasma, café au lait patches and becker's nevi. Fractionated picosecond laser can also be used for skin rejuvenation. Our experience and recent publications using these devices will be presented.

Lasers have been used for the treatment of epidermal pigmentation but can be associated with complications such as post-inflammatory hyper pigmentation (PIH). Melanocytes are known to be very susceptible to cryoinjury, however such injury is typically reported after application for cryosurgery and results in long lasting depigmentation and side effects. The dosimetry and role of controlled skin cooling on epidermal pigmentation deserves further investigation. The use of controlled cooling to reduce epidermal pigmentation will also be discussed.

Melasma and PIH are common, difficult-to-treat examples of dermal melanosis particularly troublesome in darker skin types. Melanin is retained in dermal phagocytic cells and dermal pigmentation can take >2 years to clear. Effectively, dermal melanosis is a melanin "tattoo". No highly effective treatments are available. The use of focused laser for dermal pigmentation will also be discussed.

# Synopsis

Symposium I

## The Importance of Achieving Complete Skin Clearance that Lasts

**Dr. Yung CHAN**

*Specialist in Dermatology and Venereology, Private Practice, Hong Kong*

Psoriasis is a chronic systemic immune-mediated disorder with primarily skin manifestation, patients with moderate to severe disease may suffer from severe impact in their quality of life. With the advancement in novel treatment, international authorities have set clear or almost clear skin as the treatment goals, we understand treatment that achieve clear skin greatly improve patients' quality of life, and a good long term sustainable treatment response is equally important to psoriasis patients. The discovery of interleukin (IL)-17 in the pathogenesis of psoriasis had greatly revolutionized the outcome of psoriasis patients, IL-17A inhibitors provide fast onset of action, good sustainability of response and also effective in some difficult-to-treat areas. Multicentre study showed nearly two-thirds of patients on ixekizumab achieved clear skin at week 264. In this session, clinical studies on IL-17A inhibitors in psoriasis and the management of some local cases will be discussed.

# Synopsis

Symposium I

## Multidisciplinary Approach in Psoriatic Disease's Management

**Dr. Christina WONG**

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

Psoriasis is a complex multi-systemic inflammatory disease. Recent guidelines have addressed screening, monitoring, education and treatment recommendations for the management of psoriatic comorbidities. Increasing awareness of psoriasis's comorbidities such as Psoriatic arthritis, cardiovascular disease, metabolic syndrome, inflammatory bowel disease, mental health and malignancy has prompted dermatologists to address more proactive screening and monitoring of related comorbidities. Early recognition of the disorder and timely appropriate therapy can prevent long-term complications, such as permanent joint destruction and disability. Therefore, collaboration with other specialties seems fundamental to improve the clinical outcomes of patients with psoriasis. Real-world experience with multidisciplinary approach in a tertiary centre in Hong Kong will be discussed in case scenario with treatment outcomes and strategies to move forwards.

# Synopsis

Symposium II

## Everyday Decision Making on Biologic Use for Psoriasis Patients

**Professor Peter FOLEY**

*Associate Professor, Department of Medicine, The University of Melbourne, Australia*

Dermatologists have seen significant progress in the management of psoriasis in recent years. Achieving sustainable clear/almost clear skin is possible. International guidelines such as the American Academy of Dermatology, British Association of Dermatologists and European Dermatology Forum recommend PASI 100/ PGA of clear or almost clear as the treatment target. Evidence has shown patients achieving such a target have better quality of life and improved life trajectory.

With many newer biologic agents able to achieve PASI 90 and 100, choosing the appropriate one for the patient is paramount. Some considerations include not just long-term efficacy and safety profiles but also whether the real world evidence is consistent to their clinical data.

In this lecture, Dr. FOLEY will illustrate the significance of reaching PASI 90/100 and the impact it has on his patients through the use of case studies. He will also provide insights on how to choose the appropriate biologic choice for his patients.

# Synopsis

Symposium II

## Atopic Dermatitis: Hope is on the Horizon

**Professor Peter FOLEY**

*Associate Professor, Department of Medicine, The University of Melbourne, Australia*

Atopic dermatitis (AD) is a common, chronic, relapsing, inflammatory disease with a complex pathogenesis, that manifests as a highly pruritic and painful eruption with significant physical, psychological, and economic burden. Incidence of AD has increased 2- to 3-fold in industrialized nations, impacting approximately 15% to 20% of children and 1% to 3% of adults worldwide.

Although presentation varies, AD is typically characterized by highly pruritic, eczematous, erythematous patches, papules and plaques with excoriations, crusts, and lichenification, most commonly on the flexural areas and the face. There remains a need for additional effective therapies with acceptable safety profiles for long-term use in patients with moderate-to-severe AD that will control clinical symptoms and reduce the burden of disease.

In this lecture, Dr. FOLEY will present an overview of AD pathophysiology and the advantages and limitations of current therapies, with emphasis on systemic therapies. Dr. FOLEY will also provide an overview of our current understanding of the multiple immune pathways involved in AD (e.g., key cytokines, inflammatory cells) and how these present potential immunological targets for treatment that could advance the standard of care in AD.

# Synopsis

Symposium II

## Updated Dermatitis Management Targeting Oxidative Stress

**Professor Giovanni PELLACANI**

*Professor, Department of Dermatology, University of Modena and Reggio Emilia, Italy*

Atopic dermatitis (AD) is a common chronic inflammatory skin disease; it requires long-term treatments focused on symptomatic relief. Many factors including race, environment, skin barrier dysfunction, immune regulatory Abnormalities, and microbiome have been reported to affect the pathophysiology of AD. There is extensive evidence of the link between allergic disorders such as eczema and oxidative stress. Inflammatory cells such as neutrophils, eosinophil, and macrophages produce reactive oxygen species (ROS) in human body that can cause epithelial damage and promote inflammation by reducing physiological antioxidant defenses and this may contribute positively to the pathogenesis of allergic disorders. Antioxidants inhibit lipid peroxidation by inactivating free radicals. The molecules that are capable of hindering the oxidation of other molecules by counteracting ROS are known as antioxidants. The exploration of the association between inflammation and oxidative stress in AD will enhance our understanding of the development and maintenance of the disease, which can be incorporated into formulating new treatment strategies, such as combining anti-inflammatory drugs, immune regulatory agents, skin barrier enhancers, and antioxidants. Current first-line treatments include moisturizers and topical corticosteroids. Recently, topical antioxidants have been added to moisturizer formulations to alleviate mild-to-moderate AD. The relationship between oxidative stress and atopic dermatitis, the pathogenesis of atopic dermatitis targeting oxidative stress, the effectiveness of adding anti-oxidant to emollients will be reviewed.

# Synopsis

State-of-the-Art Lecture

## Deep Dive into Pathogenesis of Atopic Dermatitis and Recent Treatment Advances

**Dr. Seemal DESAI**

*Diplomate of the American Board of Dermatology, USA*

Atopic Dermatitis (AD), a chronic inflammatory skin disease that affects both children and adults, is characterized by xerosis, pruritus, pain, and eczematous lesions. The pathogenesis of AD includes the contributing factors of environment, skin microbiota, genetics, innate immunity and adaptive immunity.

The typical treatment goals for AD are hydration and restoring barrier function, reducing inflammation and controlling symptoms. Current available treatment options fall into four categories, namely nonpharmacologic methods (i.e., emollients), phototherapy, topical pharmacotherapy (i.e., topical corticosteroids [TCS], topical calcineurin inhibitors [TCI], PDE-4 inhibitor) and systemic pharmacotherapy (i.e., antimicrobial therapy, immunosuppressive therapy, biological agents).

However, approximately one-third of children and half of adults with AD have moderate or severe disease. For those patients, topical treatment alone and phototherapy may not adequately achieve disease control often requiring systemic therapy. Currently, however, few options are available and of those that are available, most are not approved for atopic dermatitis and can be limited by their risk of adverse effects.

Representing a promising therapeutic avenue, inhibition of the conserved Janus kinase (JAK) signaling reduces the activation of multiple proinflammatory mediators involved in AD pathogenesis. JAK inhibitors existing in several forms have variable specificity for the receptor tyrosine kinases JAK1, JAK2, JAK3 and tyrosine kinase 2. The safety and efficacy of JAK inhibitors for the treatment of AD have been demonstrated in several published data and thus it is important that physicians are aware of the use of JAK inhibitors in order to promote a higher standard of treatment and quality of living among our AD patients.

# Synopsis

Symposium III

## Latest Treatment Advanced with IL-23 as Target for Psoriasis

**Professor Diamant THACI**

*Director and Full University Professor, Institute and Comprehensive Center Inflammation Medicine, University of Lübeck, Germany*

Psoriasis is a common, heterogeneous, chronic inflammatory skin disease characterized by thickened, red, scaly plaques and systemic inflammation. The systemic inflammation associated with psoriasis results in significant psoriasis-associated comorbidities such as psoriatic arthritis, cardiovascular disease, stroke, metabolic syndrome, chronic kidney disease, gastrointestinal disease, mood disorder, and malignancy. A substantial proportion of psoriasis patients have disease that is inadequately treated with these first-generation systemic therapies either because of a primary response failure or gradual loss of efficacy. Patients also occasionally discontinue therapy due to treatment-related adverse events or comorbid conditions. The discovery of the central roles for IL-23 as a crucial inflammatory mediator in the pathogenesis in group of inflammatory arthritic diseases whose symptoms span the skin, gastrointestinal tract and joints has led to a paradigm shift in the treatment of these conditions. In this talk, Prof THACI would discuss the mechanisms of action of IL-23 in the immunopathogenesis of psoriasis and related comorbidities and how the therapeutic blockade of IL-23 pathway contributes to the successful management psoriatic skin disease and psoriatic arthritis.

# Synopsis

Symposium III

## Treating Eczema in Patients with Fragile Skin

**Professor Diamant THACI**

*Director and Full University Professor, Institute and Comprehensive Center Inflammation Medicine, University of Lübeck, Germany*

Atopic dermatitis affects between 2–10% of adults and 15–30% of children and can negatively affect a patients quality of life. Advantan® contains methylprednisolone aceponate 0.1%, a potent anti-inflammatory corticosteroid with a Therapeutic Index of 2.0, indicating a favorable efficacy to adverse event rate. Advantan® is available in the cream and ointment formulation.

Advantan® has comparative efficacy with less frequency of application (once daily vs twice daily) to other similarly potent topical corticosteroids in the treatment of atopic dermatitis.

Advantan® once daily demonstrated equivalent efficacy with mometasone furoate once daily in children with atopic dermatitis, but induced less frequent and less severe atrophy and telangiectasia compared with mometasone furoate ($P<0.001$).

Advantan® provides early relief from itch in atopic dermatitis and demonstrates effective symptomatic relief in a range of eczemas. Advantan® is a generally well tolerated treatment of eczema with limited systemic effects. This makes Advantan® cream and ointment a good treatment option for eczema patients with fragile skin.

# Synopsis

Symposium III

## New Treatment Strategies for Paediatric Patients with Atopic Dermatitis

**Professor Alan IRVINE**

*Professor of Dermatology (Clinical Medicine), Trinity College Dublin, Ireland*

Atopic dermatitis (AD) is a chronic inflammatory disease with a prevalence up to 20% in children worldwide. In children with moderate-to-severe AD, skin lesions often involve a large body surface area (BSA), and the related pruritus, sleep deprivation, poor school performance, depression, and anxiety have a greater impact on quality-of-life (QOL) for patients and their caregivers than other common skin disorders.

Despite the chronic nature of AD, treatment in children is often limited to short-term topical corticosteroids (TCS), with topical calcineurin inhibitors as a second-line therapy. Guidelines discourage systemic corticosteroids owing to the risk of rebound after short-term treatment, unfavorable benefit-to-risk ratio, and multiple adverse events associated with their use. Eventually these treatments are offered only as a last resort for the most intractable cases, resulting in a large unmet need for children whose disease is inadequately controlled with topical therapy.

Dupilumab is a fully human, VelocImmune-derived monoclonal antibody that blocks the shared receptor component for IL-4 and IL-13. Dupilumab may improves treatment outcomes in children with severe atopic dermatitis inadequately controlled with topical corticosteroids, including signs, symptoms, and quality-of-life, with an acceptable safety profile. In this session, clinical data on the efficacy and safety profile of dupilumab for children with AD shall be discussed and elucidated with personal clinical experiences.

# Notes

# Acknowledgements

The Organizing Committee would like to extend their heartfelt thanks to the following sponsors for their support to the Joint Annual Scientific Meeting 2021.

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# Experience FAST-ACTING, LONG-LASTING and NON-SEDATING protection from allergies[1-4,*]

LABIXTEN® bilastine

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### Labixten® 20mg Tablet


For adults and adolescents aged ≥12 years[6]

### Labixten® 10mg Orodispersible Tablet


For children aged 6-11 years with a body weight of at least 20 kg[7]

Oral $H_1$ antihistamine meeting EAACI/ARIA criteria[8]

*For the treatment of allergic rhino-conjunctivitis (seasonal and perennial) and urticaria[6,7].

† Based upon adult studies.

‡ For children 6 to 11 years of age with a body weight of at least 20 kg, the standard dose is 10 mg Labixten® (1 orodispersible tablet) once daily; For adults and adolescents aged ≥12 years, the standard dose is 20 mg Labixten® (1 tablet) once daily[6,7].

ARIA=Allergic Rhinitis and its Impact on Asthma. EAACI=European Academy of Allergy and Clinical Immunology.

**References**: 1. Horak F, et al. Inflamm Res. 2010;59:391-398. 2. Mösges R, et al. Asia Pac Allergy. 2016;6:56-66. 3. Kuna P, et al. Clin Exp Allergy. 2009;39:1338-1347. 4. Kawauchi H, et al. Int J Mol Sci. 2019;20:213. 5. Cataldi M, et al. Clin Exp Allergy. 2019;49:1615-1623. 6. Labixten® (20 mg) Hong Kong prescribing information. 7. Labixten® (10 mg) Hong Kong prescribing information. 8. Bousquet J, et al. Curr Med Res Opin. 2012;28:131-9.

**LABIXTEN 20 mg Tablets and 10mg 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 20kg): 10 mg once daily, Adults and adolescents (≥12 years of age): 20 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; dyspepsia; gastritis; fatigue; thirst; pyrexia; asthenia. For further information consult full prescribing information. Apr 2020

For Healthcare Professionals Only.

HK/LAB/062021/143 (SEP 2021) 4IC_1779

LABIXTEN® bilastine

A. Menarini Hong Kong Limited
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MENARINI

FOR ADULTS WITH MODERATE TO SEVERE PLAQUE PSORIASIS

Offer a Chance for

# Completely Clear Skin.

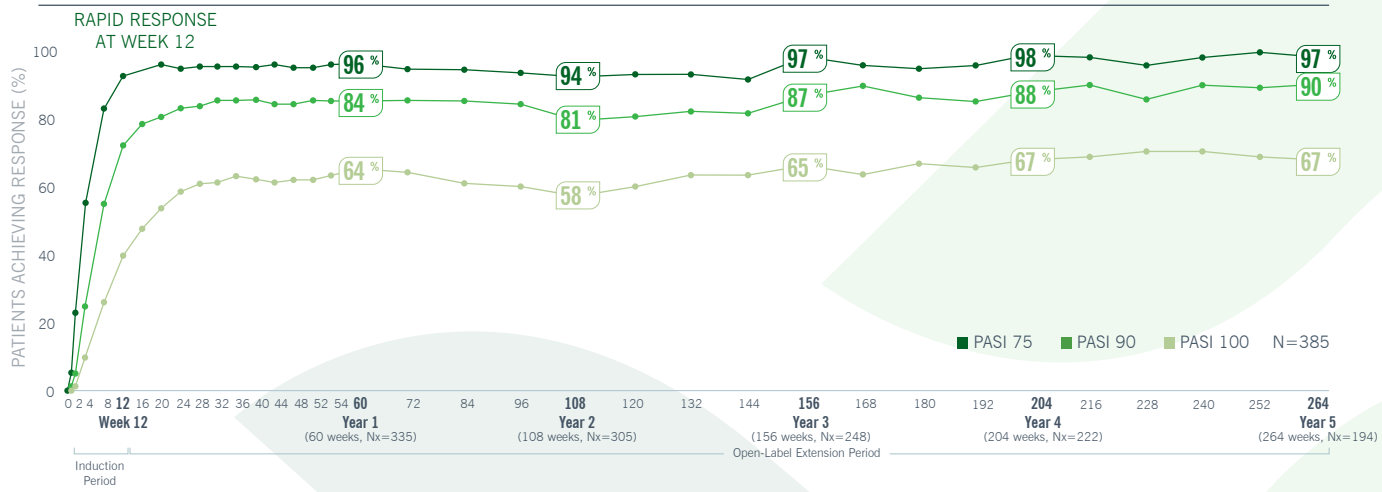
taltz® (ixekizumab)

## Sustained + Rapid

## Sustained skin clearance over 5 years of treatment[1]

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

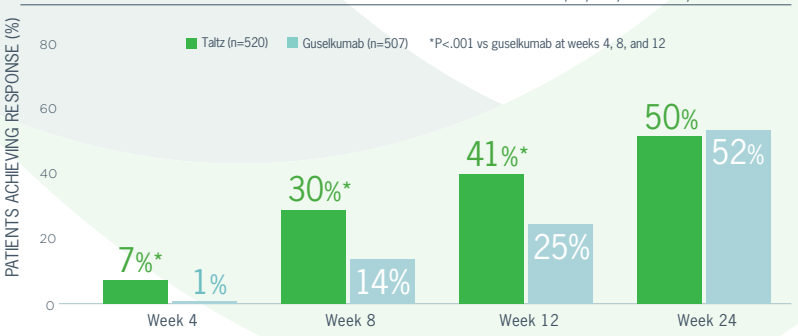
UNCOVER-3: PASI 75, PASI 90, AND PASI 100 OBSERVED RESULTS AT WEEKS 12, 60, 108, 156, 204 AND 264[1,2]




## 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.**


**Eli Lilly Asia, Inc.**
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PP-IX-HK-0169 06/2021

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## Prescription


### Treatment for Acne

- No. 1 Topical Retinoid treatment
- Guideline recommended 1st line treatment for Mild-moderate acne
- Premium oral antibiotics with less GI upset

### Treatment for Rosacea

- FDA approved topical rosacea treatments
- Guideline recommended 1st line treatment for PPR and ETR



### Treatment for Psoriasis and melasma

- Provide reliable solutions

## Consumer Solutions

### Suitable for Problematic/Sensitive Skin

- US No. 1 Dermatologist Recommended ^



### Treatment for Topical Antifungal

- World No. 1 Nail Topical Anti-fungal Brand *

^ Attitude & Usage of May 2010 US  * Nicholas Hall's global CHC database, DB6 2019 sales data value

**Acne**
BENZAC® | Differin (ADAPALENE) CREAM, GEL, 0.1% | EPIDUO FORTE (0.3%/2.5%) Gel adapalene/benzoyl peroxide | Epiduo 0.1% / 2.5% Gel adapalene / benzoyl peroxide | Tetralysal 300 Lymecycline

**Rosacea**
Rozex® Metronidazole 0.75% | MIRVASO® 3 mg/g gel brimonidine | soolantra® (IVERMECTIN) CREAM, 1%

**Psoriasis and Melasma**
Clobex® (clobetasol propionate) | desonide 0.05% Desowen® Lotion | Silkis® Smooth away Psoriasis | Tri Luma hydroquinone 4%, tretinoin 0.05%, fluocinolone acetonide 0.01%

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(Suitable for Eczema-prone Skin)
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GAL-OT001-1019

Tremfya® (guselkumab)

# First ONE IL-23 inhibitor in One PRESS


## *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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CP-254989 Aug 2021

Cosentyx®
secukinumab
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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).***

HK2003065132

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NOVARTIS

# SHARED RESULTS

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## 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®, 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

MAT-HK-2000052-1.0-06/2020 4IC_1266

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DUPIXENT® (dupilumab)
LONG-TERM CONTROL

olumiant®
(baricitinib) tablets
2 mg, 4 mg

# Olumiant is NOW APPROVED

## for moderate to severe **atopic dermatitis (AD)**

**Once-daily tablet**

Image is for representation purposes only.

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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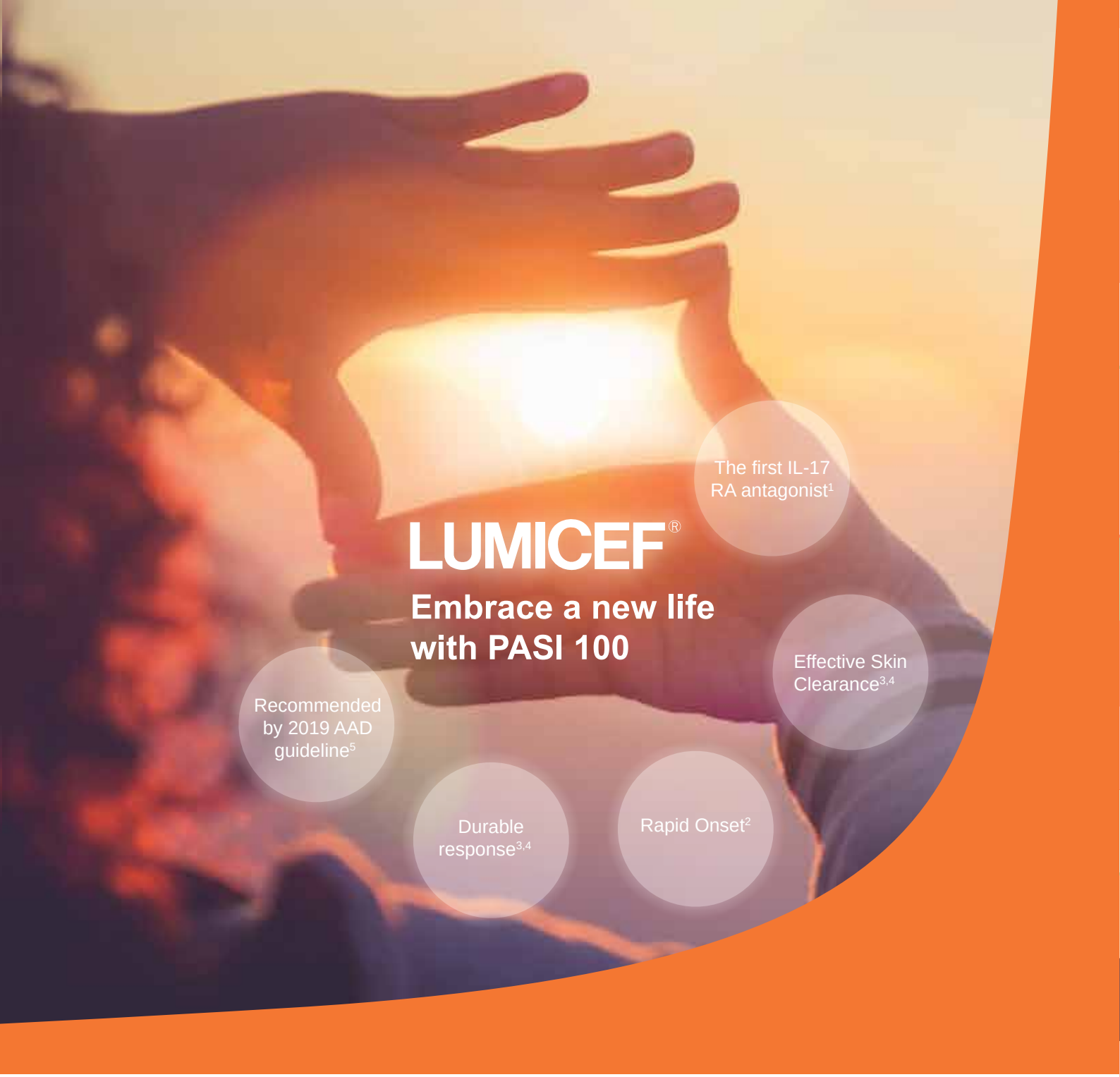


# LUMICEF® 210mg

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.
For Healthcare Professional Use Only

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