THE HONG KONG SOCIETY OF DERMATOLOGY AND VENEREOLOGY
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Annual Scientific Meeting 2022

18 September 2022 (Sunday)

Supporting Organization:

HKSPD
THE HONG KONG SOCIETY FOR PAEDIATRIC DERMATOLOGY

ACHIEVE LASTING CHANGE

DUPIXENT is the first-line systemic choice for achieving lasting change in patients as young as 6 years old with atopic dermatitis (AD)*

RAPID AND SUSTAINED CONTROL – CONSISTENT ACROSS ALL AGES

- Sustained improvement of itch, skin clearance, and QoL up to 52 weeks, with rapid control after first dose[1–16]

UNIQUE LONG-TERM SAFETY PROFILE

Only AD therapy:

- With 4-years long-term safety data in adults[17]
- Approved in patients as young as 6 years old[1]

START WITH EASE, STAY WITH CONFIDENCE

- DUPIXENT is not an immunosuppressant[1]
- 85% patient satisfaction with DUPIXENT treatment at 1 year[18**]

~340,000 AD PATIENTS TREATED WITH DUPIXENT WORLDWIDE[19]

*DUPIXENT is indicated to treat adults and adolescents ≥12 years with moderate-to-severe atopic dermatitis, and children aged 6 to 11 years with severe atopic dermatitis who are candidates for systemic therapy[1]

AD, atopic dermatitis; QoL, quality of life.

**adult population only

References: 1. DUPIXENT Summary of Product Characteristics. 2022. **2.** Blauvelt A et al. *Lancet* 2017; 389:2287–2303. **3.** Data on file (AD-1224 CSR). Sanofi and Regeneron Pharmaceuticals, Inc. 2016. **4.** Blauvelt A et al. *Lancet* 2017; 389:2287–2303. [suppl.]. **5.** Data on file (AD-1224 CSR DLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2021. **6.** Data on file (AD-1652 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. **7.** Data on file (AD-1652 CSR CDLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. **8.** Paller AS et al. *J Am Acad Dermatol* 2020; 83(5):1282–1293. **9.** Cork MJ et al. Poster presented at the Revolutionizing Atopic Dermatitis Conference; 2021; June 13; Virtual Conference. Poster 468. **10.** Data on file (AD-1652 CSR pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. **11.** Simpson EL et al. *JAMA Dermatol* 2020; 156(1):44–56. **12.** Data on file (AD-1526 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. **13.** Paller AS et al. *Am J Clin Dermatol* 2020; 21:119–131. **14.** Data on file (AD-1539 EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. **15.** Data on file (AD-1539 pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. **16.** Data on file (AD-1539 CDLQI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. **17.** Beck L et al. *Am J Clin Derm* 2022; May;23(3):393-408. **18.** Strober B et al. *JAMA Dermatol* 2022;158(2):142–150. **19.** Data on file (Patient numbers, May 2022). Sanofi and Regeneron Pharmaceuticals, Inc. 2022.

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; severe atopic dermatitis in children 6 to 11 years old 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. *Chronic rhinosinusitis with nasal polyposis (CRSwNP):* As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control(for 300 mg) **Dosage & Administration:** Subcutaneous injection. *AD adults:* Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. *ADadolescents(12-17y/o):* Body weight <60 kg - initial dose of 400 mg (two 200 mg 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. *AD Children(6-11y/o):* Body weight 15 kg – <60 kg - initial dose of 300 mg on Day 1 follow by 300 mg on Day 15, then 300 mg every 4 weeks. Bodyweight ≥60 kg - same dosage as adults. *The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg – <60 kg based on physician's assessment. *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 or adults with co-morbid severe CRSwNP- 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 <6 years or <15 kg 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 and keratitis 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:** Most common adverse reactions reported- injection site reactions, conjunctivitis, oral herpes and eosinophilia. Safety profile observed in adolescents consistent with that seen in adults. *For other undesirable effects, please refer to the full prescribing information.* **Preparation**: 2 x 300 mg/2 ml in pre-filled syringe with needle shield, 2 x 200 mg/1.14 ml 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-22.06

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DUPIXENT® (dupilumab)
CONTINUOUS CONTROL

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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 2022.

With the social distancing regulations and traveling restrictions still be in-force locally, our ASM this year will again be conducted in virtual format.

Paediatric dermatology is one of the major sessions of this year's meeting. We are honored to have Professor Richard Antaya from USA to have an in-depth discussion with us on different kinds of therapeutics for paediatric skin diseases, especially the use of biologics and JAK inhibitors.

Alopecia areata is a hot topic of the year after the incident happened at the Oscars ceremony early this year. We are privileged to have Dr. Brett King from USA to share with us the latest clinical challenges and understanding on current and future treatments of this common autoimmune disease.

Advances in the treatment of atopic dermatitis and psoriasis will be another main theme. We are grateful that Professor Thomas Bieber and Professor Andreas Pinter from Germany and Dr. Mark Tang from Singapore will share their expertise in managing atopic dermatitis. In addition, Professor Wen-hung Chung from Taiwan will discuss biologics use in psoriasis.

We are also delighted to have our local experts in dermatology and immunology to discuss with us on various hot topics. Dr. Kwun-cheung Hau will give us a talk on onychomycosis therapy. Dr. Philip Li will share with us his clinical experience on managing chronic spontaneous urticaria. Dr. Elaine Au will comment on how to choose the right drug provocation test for the right patient. Dr. Christina Wong will bring us latest clinical updates on cutaneous manifestation of COVID-19 infection, comorbidities and prognosis in hospitalized patients. Dr. William Ngan will discuss with us the salient changes involved in the updates in the CDC STI 2021 Guidelines.

Last but not least, we have three new young fellows for the New Fellows' Forum this year: Dr. Hok-fai Cheng, Dr. Stephanie Ng and Dr. On-cheung Lau. They will share with us their interesting findings from their local studies.

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

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

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

Council List (2021 – 2023)

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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. Po-tak CHAN and Dr. Shun-chin NG* HoVert Technique versus Double Scalp Punches in Alopecia Biopsy: A Pilot Study on Our Local Population *Dr. Hok-fai CHENG (Hong Kong)* Effect of Biologics on Inflammatory and Metabolic Parameters in Patients with Chronic Plaque Psoriasis *Dr. Stephanie NG (Hong Kong)* Sexual Behaviour and Risk Factors Associated with Sexually Transmitted Infections of Elderly Patients Attending Social Hygiene Services in Hong Kong *Dr. On-cheung LAU (Hong Kong)*
09:50 – 10:00	**Break**
10:00 – 11:00	**Symposium II: Paediatric Dermatology** *Chairpersons: Dr. Fong-cheng IP and Dr. Chi-keung YEUNG* The Big Bang: The Expanding Universe of Therapeutics for Paediatric Skin Disease *Professor Richard ANTAYA (USA)* Q & A
11:00 – 11:10	**Break**
11:10 – 12:45	**Symposium III: Advances in the Treatment of Hair and Nail Diseases and Chronic Spontaneous Urticaria** *Chairpersons: Dr. Tin-sik CHENG and Dr. Fong-cheng IP* Alopecia Areata: A New Understanding of Disease and Treatment *Dr. Brett KING (USA)* Bridge the "Gap": Addressing Unmet Medical Needs in Onychomycosis *Dr. Kwun-cheung HAU (Hong Kong)* Chronic Spontaneous Urticaria Disease Burden and Management in Hong Kong *Dr. Philip LI (Hong Kong)* Q & A
12:45 – 13:45	**Lunch Break**
12:50 – 13:20	**Annual General Meeting**
13:45 – 14:25	**Lunch Symposium (sponsored by AbbVie Limited)** *Chairpersons: Dr. Mimi CHANG and Dr. Christina WONG* Atopic Dermatitis: Revolution in Therapy *Professor Thomas BIEBER (Germany)* Q & A
14:25 – 14:35	**Break**

Programme

14:35 – 15:50	**Symposium IV: Advances in the Treatment of Atopic Dermatitis and Psoriasis** *Chairpersons: Dr. Mandy CHAN and Dr. Christina CHEUNG* Bringing Light for Psoriasis Patients *Professor Wen-hung CHUNG (Taiwan)* Choosing the Right Treatment for the Right Patient with Atopic Dermatitis: Experience from Singapore *Dr. Mark TANG (Singapore)* The Hidden Patient: What We Really Need to Treat in Atopic Dermatitis *Professor Andreas PINTER (Germany)* Q & A
15:50 – 16:00	**Break**
16:00 – 17:15	**Symposium V: Drug Allergy, COVID-19 & Sexually Transmitted Infections** *Chairpersons: Dr. Christina CHEUNG and Dr. King-man HO* Drug Allergy: Choosing the Right Test for the Right Patient *Dr. Elaine AU (Hong Kong)* Cutaneous Manifestation of COVID-19 Infection, Comorbidities and Prognosis in Hospitalized Patients *Dr. Christina WONG (Hong Kong)* Updates in the CDC STI 2021 Guidelines *Dr. William NGAN (Hong Kong)* Q & A
17:15 – 17:20	**Closing Remarks** Dr. Fong-cheng IP Chairman, The Hong Kong Society of Dermatology and Venereology

Academic Accreditations

Organization	Points Accredited
Hong Kong College of Community Medicine	6
The Hong Kong College of Family Physicians	5
Hong Kong College of Paediatricians	6
The Hong Kong College of Pathologists	7
Hong Kong College of Physicians	6
The College of Surgeons of Hong Kong	6
MCHK CME Programme	5

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The University of Hong Kong, Hong Kong

Symposium I: New Fellows' Forum

HoVert Technique versus Double Scalp Punches in Alopecia Biopsy: A Pilot Study on Our Local Population

Dr. Hok-fai CHENG
Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

Knowledge in hair pathology is essential in managing alopecia. Accuracy of alopecia biopsy reporting cannot be overemphasized when handling complex cases. In this context, appropriate specimen type and precise laboratory handling are crucial, and these are largely influenced by the surgical approach. Elliptical incisional biopsy is a commonplace in Hong Kong. Two-4mm scalp punches has gained popularity over the years, and is currently a global standard in alopecia diagnostics.

A pilot clinico-pathological study was carried out to examine if 4-mm scalp punch biopsy applies to our local population, and whether single or double punches is better. Each of the recruited alopecic subject was offered three 4-mm punches. One of them was grossed by HoVert technique while the other two by horizontal and vertical sectioning respectively. The microscopic assessment was cross-referenced to morphometry data, gathered from a concurrent histo-anatomical study based on normal 4-mm scalp punches of post-mortem subjects.

It was found that meticulous clinico-pathological correlation rendered alopecia diagnosis accurate and allowed tailored treatment. With 4-mm scalp punches, progress monitoring became possible. The HoVert technique excelled in reporting non-scarring alopecia but was technically demanding. The double punch technique worked in all sorts of alopecia conditions regardless of disease nature, scarring potential and clinical severity. Apart from establishing a locality-specific normal scalp morphometry, the post-mortem histo-anatomical study also clarified the morphometrical aspects of senile alopecia of our population.

Based on the findings of this study, 4-mm scalp punch works in our population and we recommend double 4-mm punches when contemplating alopecia biopsy.

Effect of Biologics on Inflammatory and Metabolic Parameters in Patients with Chronic Plaque Psoriasis

Dr. Stephanie NG
Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

Psoriasis is a chronic systemic immune-mediated inflammatory skin disease and there is well established evidence of its association with metabolic comorbidities and cardiovascular risks. The inflammatory marker C-reactive protein (CRP) has also been well described to be a marker of cardiovascular risks. The question of whether systemic treatment for psoriasis could affect more than the skin has been addressed and there are studies demonstrating the beneficial effect of systemic treatment on CRP and metabolic parameters. In the past decade, the management of psoriasis has been revolutionized with the introduction of biological therapies and there have been plenty of studies that show the efficacy of biologic agents on psoriasis, yet much is still unknown about their impact on CRP and the metabolic profile. Therefore, we conducted a retrospective study on chronic plaque psoriasis patients who received biologics treatment in the Biologics Clinic in the Department of Health. Significant reduction of CRP level and significant increase in body weight and BMI were found at 6 months, 12 months and 18 months of biologics treatment. Our study suggests that biologic agents may successfully reduce the systemic inflammatory burden in severe chronic plaque psoriasis patients shown by the reduction of CRP. However, the body weight increment after biologics should be addressed as this might attenuate the response to biologics. Therefore, regular screening of metabolic and cardiovascular risks, continuous patient education on lifestyle modification, and a holistic approach directing the underlying comorbidities are recommended during the treatment of biologics.

Symposium I: New Fellows' Forum

Sexual Behaviour and Risk Factors Associated with Sexually Transmitted Infections of Elderly Patients Attending Social Hygiene Services in Hong Kong

Dr. On-cheung LAU
Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

Hong Kong is facing the rapid aging of the population. Elderly are particularly susceptible for infectious disease due to the decrease in immunity and underlying chronic disease. In the context of sexually transmitted infections (STIs), there is increasing data showing that sexual risk-taking behaviour is not restricted to young people but also occurs in older people.

Despite this demographic change of the population structure, few attention is drawn to address the sexual behaviour and the risk of STI among the elderly population. The subject of elderly sexual health is still being long neglected and there is absence of public campaign about STIs education or prevention for elderly. In view of the progressive growth of the elderly population and the medical advancement of erectile dysfunction medications, it is expected the numbers of the elderly engaged in sexual activity will increase and STIs among the elderly can be a potential health care problem. There is an important need to assess the sexual behaviour among the elderly and the risk factors associated with STIs. In this cross-sectional study, we aimed at identifying the sexual behaviour and the risk factors associated with casual sex and STIs in elderly patients attending social hygiene services.

A total 341 elderly participants were recruited. Among the participants, 73.3% (N=250) engaged in casual sex within 1 year and most of them 70.4% (N=240) did not have condom use during sexual intercourse. 79.2% (N=270) patients reported to have at least 1 regular partner in the past 3 months and 8.5% reported to have commercial sex worker (CSW) visit within 1 week. Age, marital status-married, working and use of condom were found to be associated with the casual sex behaviour. No single factor was found to be significantly related to the current STIs.

This study provides information on Hong Kong elderly sexual behaviour and factors associated with casual sex and STIs. The results indicated a need to implement education on safe sex with an emphasis on the elderly population and health care professional should be aware of the sexuality of elderly patients in their primary health care setting.

Symposium II: Paediatric Dermatology

The Big Bang: The Expanding Universe of Therapeutics for Paediatric Skin Disease

Professor Richard ANTAYA
Professor of Dermatology, Pediatrics and Nursing, Yale University School of Medicine, USA

Since the emergence of hydrocortisone, a new intervention for inflammatory skin disease has emerged roughly every 20 years. We welcomed topical calcineurin inhibitors in the early 2000's but today the biologics and JAK inhibitors are the focus of innovation, and we have witnessed more medications for severe inflammatory pediatric skin disease coming to market than ever before.

Regarding biologics, IL-17a and IL12/23 inhibitors have been approved by the FDA for psoriasis down to 6 years of age. IL-4 and IL-13 have been shown to be central to the pathogenesis of AD. Dupilumab, the first biologic approved to treat AD, inhibits both cytokines and is now approved for use in children as young as 6 months. Tralokinumab binds IL-13 and is FDA approved for treatment of adults with AD. FDA submission is anticipated in the next several months.

JAK inhibitors are perhaps the hottest topic in atopic dermatitis. Ruxolitinib cream 1.5% is FDA approved for treatment of mild-to-moderate AD in patients 12 years and older. Upadacitinib is an oral JAK inhibitor approved for use in adolescent and adult AD patients. Both topical and oral JAKs have been associated with development of acne, a fairly important side effect when treating teenagers. Both oral and topical also carry boxed safety warnings.

In the pipeline for pediatric AD are inhibitors of IL-13 and IL-31, as well as the JAK inhibitor baricitinib.

Symposium III: Advances in the Treatment of Hair and Nail Diseases and Chronic Spontaneous Urticaria

Alopecia Areata: A New Understanding of Disease and Treatment

Dr. Brett KING
Associate Professor of Dermatology, Yale University School of Medicine, USA

Laboratory evaluation of patients who present with alopecia areata is common but is typically not necessary. Alopecia areata severity classification has largely been ignored until recently, and the terms alopecia totalis and alopecia universalis may no longer be helpful. Janus kinase (JAK) inhibitors have ushered in a new era in alopecia areata, an era marked by the possibility of reliably effective treatment for severe disease. More than ever before, it is paramount to address these and other clinical challenges and understand current and future treatments of this common autoimmune disease.

Symposium III: Advances in the Treatment of Hair and Nail Diseases and Chronic Spontaneous Urticaria

Bridge the "Gap": Addressing Unmet Medical Needs in Onychomycosis

Dr. Kwun-cheung HAU
Specialist in Dermatology and Venereology, Private Practice, Hong Kong

Onychomycosis of the toenails caused by dermatophytes is a common disease that affects not only cosmetic appearance but also physical and psychological lives of patients. Early medical attention is required to eliminate fungal infection.

In recent years topical azole therapy has been established to be clinically effective for mild-moderate cases. However, there are certain nail presentations and patient groups that are commonly seen in clinical practice which do not yet have a standard treatment recommendation.

In this lecture Dr. Hau presents emerging evidence that addresses these challenges in severe tinea unguium, dermatophytoma, and onychomycosis in elderly and diabetic patients, that may help to inform treatment choice for each individual patient.

Symposium III: Advances in the Treatment of Hair and Nail Diseases and Chronic Spontaneous Urticaria

Chronic Spontaneous Urticaria Disease Burden and Management in Hong Kong

Dr. Philip LI
Division Chief (Academic) and Clinical Assistant Professor, Division of Rheumatology & Clinical Immunology, Department of Medicine, The University of Hong Kong, Hong Kong

Chronic spontaneous urticaria (CSU) is a common disease worldwide with a prevalence of around 1% in Asian populations. CSU has a significant impact on health-related quality of life, affecting performance at school and work and is associated with a high consumption of medical resources, high treatment costs and other direct and indirect costs to society.

Historically, physicians have used H1-antihistamines as the standard of care in CSU. According to the current EAACI/GA2LEN/EDF/WAO guidelines for urticaria, the recommended first and second-line therapies are standard-dosed and up-dosed (up to 4 times the approved dose) second-generation, non-sedating H1-antihistamine, respectively. However, many patients continue to experience CSU signs and symptoms despite taking these treatments, with as many as 60% of patients with CSU not achieving symptom control at approved doses.

Following the mentioned guidelines the goal of treatment is to treat the disease until it is gone and as efficiently and safely as possible aiming at a continuous UAS7 = 0, complete control and a normalization of quality of life.

Locally from our Urticaria Clinic's experience we saw considerable differences in patients' outcomes with appropriate use of third line treatment and significant improvement of disease activity.

Lunch Symposium

Atopic Dermatitis: Revolution in Therapy

Professor Thomas BIEBER
Professor for Dermatology and Allergology, University of Bonn, Germany

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, Prof. Bieber will present an overview on AD management strategy and limitations of current therapies with emphasis on systemic therapies. Prof. Bieber will also share clinical data of currently approved AD treatments, including Upadacitinib. He will also share how these AD treatments could help to address key gaps in AD management.

Symposium IV: Advances in the Treatment of Atopic Dermatitis and Psoriasis

Bringing Light for Psoriasis Patients

Professor Wen-hung CHUNG
Director, Department of Dermatology and Drug Hypersensitivity Clinical and Research Center, Chang Gung Memorial Hospital, Taipei, Taiwan

Psoriasis has significant impact on a patient's well-being, involving physical, emotional, psychological and sexual impacts to quality of life. Hence, most psoriasis patients in Taiwan desire complete resolution of skin lesions regardless of manifestation and severity. The three new IL-17 inhibitors, including brodalumab, have played a major positive role in the updated biologic therapies for moderate-to-severe psoriasis. Before introducing IL-17 and IL-23 cytokines, four TNF-α agents and one IL 12/23 agent have been the only biologic drugs approved for Psoriasis worldwide over the past two decades.

Now that we understand that both IL-17 and IL-23 cytokines play an important and significant role in the immunopathogenesis of psoriasis, IL-17 and IL-23 biologic agents have produced more significant PASI-75, PASI-90 and even PASI-100 quality scores than we have ever seen before.

In this discussion of one of the main three IL-17 biologic agents, brodalumab is a monoclonal antibody which binds with high affinity to the interleukin (IL) 17 receptor A. It is used to treat moderate-to-severe plaque psoriasis and is also effective on patients who have lost response or failed to respond to other biological therapies. We will review the significant quality of improvement seen in moderate-to-severe-psoriasis patients, details regarding dosing, as well as the important safety issues of brodalumab as a major first line biologic agent in our Psoriasis population.

Symposium IV: Advances in the Treatment of Atopic Dermatitis and Psoriasis

Choosing the Right Treatment for the Right Patient with Atopic Dermatitis: Experience from Singapore

Dr. Mark TANG
Medical Director and Consultant Dermatologist, The Skin Specialists & Laser Clinic, Mount Alvernia Medical Centre, Singapore

Atopic dermatitis is a highly prevalent chronic, inflammatory skin disease with a significant burden on patients of all ages, their families, and healthcare systems. This sharing session presents clinical experience from my team and myself addressing several clinical questions that arise in the management and care of moderate-to-severe atopic dermatitis with advanced therapies based on the available evidence. Our clinical decisions were grounded from existing guidelines on the treatment of atopic dermatitis, publications concerning new treatments, and expert-based recommendations. Our decisions also include considerations on atopic dermatitis severity, indications for initiating biologic agents or other therapies, parameters to be considered in the treatment choice, particular treatment goals, and recommendations for the use, screening and monitoring of these therapies.

Symposium IV: Advances in the Treatment of Atopic Dermatitis and Psoriasis

The Hidden Patient: What We Really Need to Treat in Atopic Dermatitis

Professor Andreas PINTER
Director, Clinical Research, Department of Dermatology, Venereology, and Allergology, University Hospital Frankfurt am Main, Germany

Atopic dermatitis is associated with lower overall health rating and life satisfaction, impaired quality of life (QoL) related to mental health and skin related QoL, where more than half of all affected adults reported that it limited their lifestyle.

In the lecture, Professor Pinter will review the key clinical data from the Phase 3 Baricitinib trials in the management of moderate-to-severe atopic dermatitis (AD). Look in the recent real-world data and long-term safety of Baricitinib for treating this chronic skin disease. And then use a case-based approach to highlight key benefits for patients with AD using JAK inhibition to bring out the disease impact about atopic dermatitis from patients' perspective.

What will be discussed during the lecture:

- The impact of atopic dermatitis on patients' lives beyond the skin
- What patients want from atopic dermatitis management
- How Olumiant meets short-term, long-term, and adaptable atopic dermatitis control from patients' perspective
- How to translate patient reported outcomes of Olumiant studies into clinical practice
- Real-life Olumiant treatment experience

Symposium V: Drug Allergy, COVID-19 & Sexually Transmitted Infections

Drug Allergy: Choosing the Right Test for the Right Patient

Dr. Elaine AU
Consultant, Division of Clinical Immunology, Department of Pathology, Queen Mary Hospital, Hong Kong

In clinical practice, we often encounter patients labelled with drug allergy history. In standard care, avoidance of suspected allergic items and potential cross reactive medications is advised. The allergy labelling has significant implication, especially for common drugs such as penicillin or multiple allergy labelling, since the restriction of drug choice is lifelong. It is well reported in literature that quite a significant proportion of patients, after careful assessment, that the allergic labelling can be revised.

The gold standard for the diagnosis of drug hypersensitivity is supervised drug provocation tests (DPT). However, DPT involves re-exposing patients to suspected allergens, that can be risky. Moreover, DPT may not be feasible or indicated in every setting. Therefore, proper assessment starting with a comprehensive history taking, followed by dedicated workup and risk stratification is important, before consideration of DPT. In general, approach to drug allergy workup can be broadly divided into immediate and delayed type reactions. Skin tests are important part of the workup. In vitro tests in general has lower sensitivity, however, it helps to complement skin tests in settings when skin test is not feasible or preferred. Moreover, complementary use of these assays may also help to enhance the overall diagnostic yield. Options of in-vitro tests for immediate type hypersensitivity includes specific Immunoglobulin E (SigE) and basophil activation test (BAT), while cell mediated immune response is commonly studied in delayed type hypersensitivity reaction, such as lymphocyte transformation test (LTT) and Enzyme-linked immunospot (ELISPOT) assays. Other assays, such as cytokine release measurement, HLA genotyping, etc have also been applied in the field of drug allergy diagnostic workup.

Symposium V: Drug Allergy, COVID-19 & Sexually Transmitted Infections

Cutaneous Manifestation of COVID-19 Infection, Comorbidities and Prognosis in Hospitalized Patients

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

Coronavirus disease (COVID-19) is an infectious disease caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). It was first identified in December 2019 in Wuhan, Hubei, China and has resulted in an ongoing pandemic. According to World Health Organization (WHO) Coronavirus (COVID-19) data, as of 24 August 2022, more than 594.4 million cumulative confirmed cases have been reported across 188 countries and territories with more than 6.45 million deaths, while in Hong Kong, there were 330,670 confirmed cases and 9308 (2.81%) reported death in May. With the dynamic infectious control, increasing number of public vaccination and early treatment offered to those at high risk, although the number of cumulative confirmed cases has raised to 1.45 million in the 5th and 6th waves, the incidence of rate actually dropped to 0.66% in August (with cumulative death 9605 cases). The common symptoms include fever, sore throat, cough, malaise, shortness of breath, and loss of smell or taste. While most people have mild symptoms, some develop acute respiratory distress syndrome (ARDS), which is possibly precipitated by cytokine storm, multiorgan failure, septic shock, and death. Increasing evidence showed that rash could be one of the early or sole symptoms in those "asymptomatic" or pauci-symptomatic carriers. Early detection of this "silent" sign and diagnosis is crucial in epidemiology control. As asymptomatic or pauci-symptomatic cases may constitute the source of continuing spread in the community. Various cases of diverse dermatological manifestations of COVID-19 infection have been reported including maculopapular, urticarial, livedo reticularis, pernio/chilblain, vasculitis, vesicular and papulo-necrotic eruption. The incidence of cutaneous manifestations in COVID-19 patients varies in different case series, possibly due to the under-recognition of those asymptomatic or pauci-symptomatic cases, ranging from 0.2% to 20.4%. It has also been suggested that patients with a rash may have a better prognosis due to mounting sufficient immunity in the body to fight against the virus. Whether there is a direct relationship between skin manifestations, viral load, and comorbidities and the clinical outcome remains unknown. According to the Public health ordinance in Hong Kong, all patients who tested positive for COVID-19 were required for admission to the hospital for quarantine regardless of symptoms in the early phase of pandemic. The incidence rate, pattern of clinical and cutaneous manifestations among COVID-19 infected hospitalized patients in a tertiary centre and its association with viral load, comorbidities, and prognosis will be presented and discussed.

Symposium V: Drug Allergy, COVID-19 & Sexually Transmitted Infections

Updates in the CDC STI 2021 Guidelines

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

Medicine is an everchanging science and so is the field of sexually transmitted diseases. As more knowledge accumulates and changes in pathogen behavior becomes more common, there is a need for guideline update. The United States Centers for Disease Control and Prevention has updated its 2015 guidelines to a newer one in 2021. In this lecture, the speaker will discuss with the audience the salient changes involved.

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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References: 1. RINVOQ® Hong Kong Prescribing Information Feb 2022. 2. Guttman-Yassky E, Teixeira H, Simpson E, et al. Once-daily upadacitinib versus placebo in adolescents and adults with moderate-to-severe atopic dermatitis (Measure Up 1 and Measure Up 2): results from two replicate double-blind, randomised controlled phase 3 trials. Lancet. 2021; 397(10290): 2151-2168.

EASI: Eczema Activity and Severity Index, EASI 75/90: at least a 75% or 90% improvement in EASI score from baseline, NRS: numerical rating scale

RINVOQ abbreviated product information

Presentation: Prolonged-release tablet: Upadacitinib 15/30 mg Indication: Rheumatoid arthritis: 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 (DMARDs) as monotherapy or in combination with methotrexate. Psoriatic arthritis: treatment of active psoriatic arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more DMARDs as monotherapy or in combination with methotrexate. Ankylosing spondylitis: treatment of active ankylosing spondylitis in adult patients who have responded inadequately to conventional therapy. Atopic dermatitis: treatment of moderate to severe atopic dermatitis in adults and adolescents 12 years and older who are candidates for systemic therapy. Dosage and administration: Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis: 15 mg once daily. Atopic dermatitis: Adult: 15 mg or 30 mg once daily based on individual patient presentation. Adult ≥ 65 years of age: 15 mg once daily. Adolescent 12-17 yr, ≥30kg: 15mg once daily. Contraindications: Known hypersensitivity to upadacitinib or any of its excipients; active tuberculosis or active serious infections; severe hepatic impairment; pregnancy. Warning and Precautions: Immunosuppressive medical products: Upadacitinib has not been evaluated with other potent immunosuppressants, combination use is not recommended. Serious infections: Upadacitinib should not be initiated in patients with an active, serious infection, including localised infections. Closely monitor for the development of signs and symptoms of infection during and after treatment. Interrupt upadacitinib if serious or opportunistic infection develops. Use with caution in the elderly ≥ 65 years of age. Tuberculosis (TB): Screen for TB before initiation. Upadacitinib should not be given to patients with active TB. Monitor for signs and symptoms of TB. Anti-TB therapy should be considered prior to initiation of upadacitinib in patients with previously untreated latent TB or in patients with risk factors for TB infection. Viral reactivation: If herpes zoster develops, upadacitinib interruption should be considered until the episode resolves. Screen for viral hepatitis and monitor for reactivation before starting and during therapy. Vaccination: Use of live, attenuated vaccines during or immediately prior to upadacitinib is not recommended. Prior to initiating upadacitinib, it is recommended that patients be brought up to date with all immunisations, including prophylactic zoster vaccinations, in agreement with current immunisation guidelines. Malignancy: The risks and benefits of upadacitinib treatment should be considered prior to initiating therapy in patients with a known malignancy other than a successfully treated non-melanoma skin cancer (NMSC) or when considering continuing upadacitinib in patients who develop a malignancy. Periodic skin examination is recommended for patients who are at increased risk for skin cancer. Haematological abnormalities: Upadacitinib should not be initiated, or should be temporarily interrupted, in patients with an ANC < 1 x 10^9 cells/L, ALC < 0.5 x 10^9 cells/L or haemoglobin < 8 g/dL. Diverticulitis: Upadacitinib should be used with caution in patients with diverticular disease and especially in patients chronically treated with concomitant medications associated with an increased risk of diverticulitis. Cardiovascular risk: Manage risk factors of cardiovascular disorders as part of usual standard of care. Lipids: Dose-dependent increases in lipid parameters, including total cholesterol, low-density lipoprotein (LDL) cholesterol, and high-density lipoprotein (HDL) cholesterol. Hepatic transaminase elevations: Evaluate at baseline and thereafter according to routine patient management. If increase in ALT or AST are observed and drug-induced liver injury is suspected, upadacitinib therapy should be interrupted until this diagnosis is excluded. Venous thromboembolism: Use with caution in patients at high risk for DVT/PE. If clinical features of DVT/PE occur, upadacitinib treatment should be discontinued and patients should be evaluated promptly, followed by appropriate treatment. Women with childbearing potential: Use effective contraception during treatment and for 4 weeks following the final dose. Pregnancy: Upadacitinib is contraindicated during pregnancy. Breast feeding: It is unknown whether upadacitinib/metabolites are excreted in human milk. Upadacitinib should not be used during breast-feeding. Interactions: Metabolism mainly by CYP3A4. Coadministration with Strong CYP3A4 inhibitors: Upadacitinib 15mg once daily should be used with caution in patients receiving chronic treatment with strong CYP3A4 inhibitors. Upadacitinib 30 mg once daily dose is not recommended for patients receiving chronic treatment with strong CYP3A4 inhibitors. Consider alternatives to strong CYP3A4 inhibitor when used in the long-term. Coadministration with Strong CYP3A4 inducers: Monitor for changes in disease activity. Undesirable effects: Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis - upper respiratory tract infections, blood creatine phosphokinase (CPK) increased, alanine transaminase increased, bronchitis, nausea, cough, aspartate transaminase increased, and hypercholesterolaemia; Atopic dermatitis - upper respiratory tract infections, acne, herpes simplex, headache, CPK increased, cough, folliculitis, abdominal pain, nausea, neutropenia, pyrexia, and influenza. Please read the full prescribing information before prescribing. Full prescribing information is available upon request. HK_API Rinvoq PI FEB 2022

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Clinically proven to improve erythema and xerosis[3]*

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90% of mild-moderate AD patients achieved PGE improvement[3]*

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*p≤0.001 vs control arm.

Study design[2]: A single-center, randomized, double-blind controlled study evaluated the efficacy and safety of Relizema™ Cream twice daily vs vehicle for 21 days in patients suffering from mild to moderate AD. Patients aged ≥18 years with AD grading sore of 3-5 according to Rajka and Langeland's criteria and cutaneous surface involvement <20% were included (n=20 per group). Patients were excluded if they had skin diseases other that AD, topical treatment in the last ten days, administered systemic anti-histamine, NSAIDs and corticosteroids in the last 2 weeks. Study endpoints were the improvement in signs and symptoms, as measured by PGE of clinical response, and patients reported severity of pruritus according to VAS.

Indications: Relizema™ cream is indicated for the treatment of itching and flushing associated with dermatitis, including atopic and contact dermatitis. Due to its dermaprotective action it helps in maintaining and restoring the physiological skin barrier. Directions for use: Apply Relizema™ cream on the affected area two or three times a day as needed. For external use only. Avoid contact with eyes and the mucosa. In case of contact, rinse with plenty of water. Do not use in the event of hypersensitivity to one of the ingredients. Store below 25°C, away from direct heat. Contraindications/Undesired effects: Biocompatibility studies have shown no contraindications or undesired effects. If either occurs, consult physician or pharmacist.

AD: Atopic dermatitis. NSAIDs: Non-steroidal anti-inflammatory drugs. PGE: Physician's Global Evaluation.

References: 1. Nemelka O, Bleidel D, Fabrizi G, et al. Experimental survey of a new topical anti-oxidant based on furfuryl palmitate in the treatment of child's and baby's dermatitis with eczema: results from a multicenter clinical investigation. Minerva Pediatr. 2002;54:465-474. 2. Pigatto PD & Diani M. Beneficial effects of antioxidant furfuryl palmitate in non-pharmacologic treatments (prescription emollient devices, PEDs) for atopic dermatitis and related skin disorders. 2018;8:339-347. 3. Pigatto PD, Lauriola MM, Vaccari G. A single-center, randomized, double-blind, perspective, controlled study of efficacy and safety of a furpalmate-containing cream versus vehicle in the treatment of 40 adult patients with mild to moderate atopic dermatitis. In: Poster session 20th EADV Congress, 20–24 October 2011, Lisbon, Portugal.

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Onset of action within 1 hour[1,†]

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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; dyspesia; gastritis; fatigue; thirst; pyrexia; asthenia. For further information consult full prescribing information. Apr 2020

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HZ = Herpes zoster
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Indication: SHINGRIX is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older; and adults 18 years of age or older at increased risk of HZ. The use of Shingrix should be in accordance with official recommendations.

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

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

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

For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong) [or (853) 2871 5569 (Macau)], or send an email to us at HKAdverseEvent@gsk.com. Please read the full prescribing information prior to administration. Full Prescribing Information is available upon request at GSK, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsim Sha Tsui, HK.

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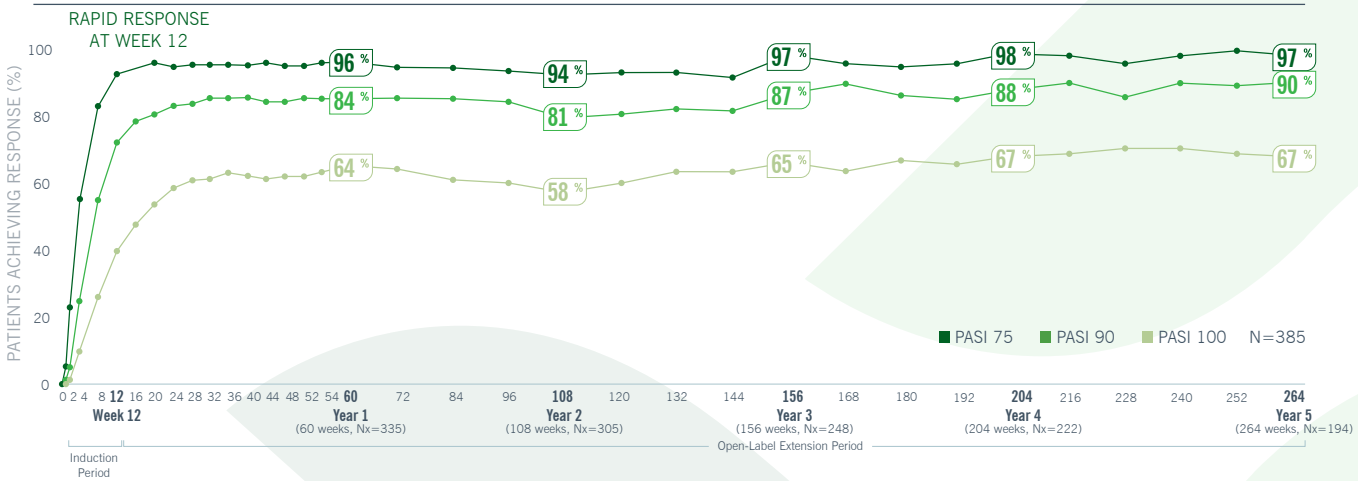
Sustained skin clearance over 5 years of treatment[1]

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

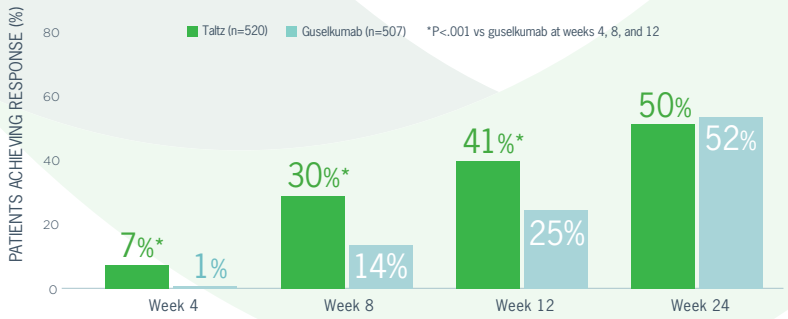
UNCOVER-3: PASI 75, PASI 90, AND PASI 100 OBSERVED RESULTS AT WEEKS 12, 60, 108, 156, 204 AND 264[1,2]



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.

Eli Lilly Asia, Inc.
Room 3203-06, 32/F, Chubb Tower, Windsor House,
311 Gloucester Road, Causeway Bay,
Hong Kong.Tel: 2572 0160

PP-IX-HK-0169 06/2021

Lilly

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.

PP-BA-HK-0185 07/21

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Cetaphil® PRO Itch Control

Your recommendation can make the difference to their eczema-prone skin

Cleansing Foam

1 Protect the skin from drying out and relieve irritation[4]

- Immediately increases skin hydration and sustained for 8 hours[5]

Moisturizing Cream

2 Restore the skin barrier

- 24h skin barrier protection
- Protects skin irritation occurrence[3]

Moisturizing Foam

3 Break the itch-scratch cycle

- Relief from itch and dryness[1]
- Sustained soothing and calming effect[2]

SymCalmin® is a solution of a synthetic avenanthramide that is used as an anti-irritant/anti-itch with anti-histaminic properties. Avenanthramides are responsible for anti-inflammatory/anti-itchj properties.

Cetaphil® PRO AD Derma

Skin Restoring Wash

1 Help soothe itch and reduce redness, dryness and irritation[6]

- Significantly decrease burning, stinging and scaling[6]

Skin Restoring Moisturizer

2 Help restore skin barrier function[6]

- Improve surface hydration[6]
- Provide long-lasting hydration[6]

Filaggrin break down products restore moisture to help rebuild the damaged skin barrier.[6]
Ceramide precursors help replenish the skin's natural liqids.[6]

References : 1. Galderma. Formulation claim. 2. Galderma. Data on file (RD.03.SPR.105653). 3. Galderma. Data on file (RD.03.SPR.105328). 4. Galderma. Data on file (DCC13U019). 5. Galderma. Data on file (DCC13K031GR1). 6. Proksch E et al. Skin lipids and epidermal differentiation in atopic dermatitis.

GALDERMA

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GALDERMA

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PRECISION *WHERE IT MATTERS.*
AKLIEF® Cream

The next generation topical retinoid for facial and truncal acne [1,2]

Stay tuned to our official launch!

Please contact
Galderma Sales Representatives
by Tel : 2824 0333 for more information

AKLIEF® Cream contains the retinoid molecule trifarotene, which specifically targets RAR-γ, the most common retinoic acid receptor in the skin.[1]

1. Aubert J, et al. Br J Dermatol 2018;179(2):442–56; 2. Tan J, et al. J Am Acad Dermatol 2019;80(6):1691–99

Success Demands Precision

Aklief® API

Composition: one gram of cream contains: Trifarotene 50 mcg. For the full list of excipients, see section 6.1 of SmPC. Therapeutic indications: cutaneous treatment of Acne Vulgaris of the face and/ or the trunk in patients from 12 years of age and older, when many comedones, papules and pustules are present. Posology: Apply a thin layer of Aklief cream to the areas of the face and/or trunk once a day, in the evening, on clean and dry skin. Contraindications: Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of SmPC, pregnancy, and women planning a pregnancy. Special warnings and precautions for use: Erythema, scaling, dryness, and stinging/burning may be experienced with use of Aklief cream. To mitigate the risk of such reactions, patients should be instructed to use a moisturizer from the initiation of treatment, and, if appropriate, reduce the frequency of application of Aklief cream, or suspend use temporarily. Despite mitigation measures, if severe reactions persist the treatment may be discontinued. The product should not be applied to cuts, abrasions, eczematous or sunburned skin. As with other retinoids, use of "waxing" as a depilatory method should be avoided on skin treated with Aklief. If a reaction suggesting sensitivity to any component of the formula occurs, the use of Aklief should be discontinued. Caution should be exercised if cosmetics or acne medications with desquamative, irritant or drying effects are concomitantly used with the medicinal product, as they may produce additive irritant effects. Aklief should not come into contact with the eyes, eyelids, lips, or mucous membranes. If the product enter the eye, wash immediately and abundantly with luke warm water. Excessive exposure to sunlight, including sunlamps or phototherapy should be avoided during the treatment. Use of a broad-spectrum, water-resistant sunscreen with a Sun Protection Factor (SPF) of 30 or higher and protective clothing over treated areas is recommended when exposure cannot be avoided. This product contains propylene glycol (E1520) that may cause skin irritation. Interaction: clinical drug-drug interaction study has shown that topical application of trifarotene did not affect the circulating concentrations of hormonal contraceptives (ethinyl estradiol and levonorgestrel) administered by oral route. No clinical drug-drug interaction studies were performed to assess effects of other drugs on trifarotene systemic levels. There is no data on the pharmacodynamic interaction potential of trifarotene. Caution should be exercised if cosmetics or acne medications with desquamative, irritant or drying effects are concomitantly used with the medicinal product, as they may produce additive irritant effects. Undesirable effects: Local cutaneous reactions such as erythema, scaling, dryness, and stinging/ burning are very common. The other "commonly" reported adverse reactions are application site irritation, application site pruritus and sunburn. Please read the Summary of Product Characteristics for more information.

 AKL-PS001-0804

AKLIEF
(trifarotene) Cream, 0.005%

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Corporation Limited

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Tremfya®
(guselkumab)

Tremfya® Ultra-responders maintained PASI 0 throughout 3 years[1]

Ultra-responders: Tremfya® -treated patients maintained PASI=0 at all visits for at least 156 consecutive weeks
Reference 1. Costanzo A, et al. J Am Acad Dermatol. 2021;85(3):AB108.

Tremfya® solution for injection in pre-filled syringe 100mg/1ml
Tremfya® solution for injection in pre-filled pen 100 mg/1 mL
ABBREVIATED PRESCRIBING INFORMATION

ACTIVE INGREDIENT(S): Guselkumab **INDICATION(S):** Plaque psoriasis - Treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. Psoriatic arthritis - Tremfya, alone or in combination with methotrexate, for the treatment of active psoriatic arthritis in adult patients who have had an inadequate response or who have been intolerant to a prior disease-modifying antirheumatic drug therapy. **DOSAGE & ADMINISTRATION:** Plaque psoriasis - 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. Psoriatic arthritis - 100 mg by subcutaneous injection at weeks 0 and 4, followed by a maintenance dose every 8 weeks. For patients at high risk for joint damage according to clinical judgement, a dose of 100 mg every 4 weeks may be considered. Consider discontinuing treatment in patients who have shown no response after 24 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, including anaphylaxis, have been reported in the post-marketing setting. Some serious hypersensitivity reactions 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. Hepatic transaminase elevations: In psoriatic arthritis clinical studies, an increased incidence of liver enzyme elevations was observed in patients treated with Tremfya q4w compared to patients treated with Tremfya q8w or placebo. When prescribing Tremfya q4w in psoriatic arthritis, it is recommended to evaluate liver enzymes at baseline and thereafter. If increases in ALT or AST are observed and drug-induced liver injury is suspected, temporarily interrupt Tremfya until this diagnosis is excluded. 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:** Respiratory tract 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 in psoriasis studies. PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.
Tremfya aPI ver 3.0

Janssen, a division of Johnson & Johnson (HK) Ltd.
13/F, Tower 1, Grand Century Place, 193 Prince Edward Road West, Mongkok, Kowloon, Hong Kong
Tel: 2736 1711 Fax: 2736 1926

CP-335040 August 2022

Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

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

Kyowa Kirin Hong Kong Co., Ltd.
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KKHK-LMC-04-APR2021

KYOWA KIRIN

Protopic®

(tacrolimus 0.03%, 0.1% ointment)

Guidelines recommend the proactive, intermittent use of Protopic® twice-weekly to prevent relapses and for long-term AD management[1,2]

Incorporate Protopic® maintenance therapy for flare prevention

Children 2–15 years	Adults ≥16 years
Protopic® 0.03% **2x DAILY** treatment	**Protopic®** 0.1% or 0.03% **2x DAILY** treatment
Flares cleared	Flares cleared
Protopic® 0.03% **2x WEEKLY** maintenance treatment	**Protopic®** 0.1% or 0.03% **2x WEEKLY** maintenance treatment

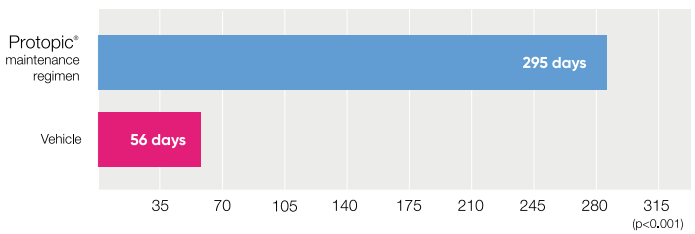
If signs of flare, initiation of 2x daily treatment may be advised

Protopic® maintenance regimen prolongs time-to-first-flare[3]

The median time to the first disease exacerbation requiring substantial therapeutic intervention was significantly longer for patients on Protopic® maintenance regimen.

Study details: Patients were treated with Protopic® for up to 6 weeks in the open-label period. Patients entered the disease control period when IGA score of ≤2 was achieved, and were randomised to receive either Protopic® or a vehicle control twice-weekly for 12 months.

Median time until first disease exacerbation



Adapted from Thaci D et al. Br J Dermatol 2008; 159:1348–1356

Scan to view Protopic® Prescribing Information

Illustrative patient profile, not actual patient

References:
1. Eichenfield LF et al. JAAD. 2014 Jul;71(1):116-32.
2. Ring J et al. JEADV. 2012; Aug;26(8):1045-60.
3. Thaci D et al. Br J Dermatol 2008; 159:1348–1356.

For Healthcare Professionals Only. Full Prescribing Information available upon request.

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Clinically proven to reduce itch and irritation associated with dry skin in 1 hour[1]

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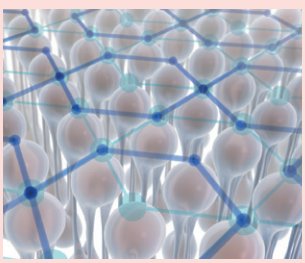
High Lipid content: 40% essential lipids

Palmitamide MEA (PEA)± : naturally occurring fatty acid. To help rapidly soothe and relieve skin that is very dry, irritated and reactive



After 1 hour of 1st application[1]

76%* reduction in itch associated with dry skin

*mean subject rating (n=45) versus baseline after 1 hour

After 1 hour of 1st application[1]

73%** reduction in skin irritation associated with dry skin

**mean subject rating (n=45) versus baseline after 1 hour

After 4 weeks of application[1]

85%*** reduction in skin irritation associated with dry skin

***mean subject rating (n=45) versus baseline after 4 weeks' twice daily use

± PEA, palmitoylethanolamide

1. Cosmetic study to investigate the safety, acceptability and efficiency of M0338 in subject with moderately dry to very dry skin with signs and symptoms of redness, irritation, inflammation or itch.

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Staquis™

(crisaborole) ointment 2% w/w

First and only topical PDE4 inhibitor[2]

in Hong Kong for **mild-to-moderate** atopic dermatitis (AD)[1] that:

- acts as an **anti-inflammatory** agent and helps to **improve skin barrier function**[*,3,5]
- established **safety & effectiveness** in patients as young as **3 months**[1]
- has demonstrated a **long-term safety profile up to 48 weeks**[4]

Prescribe Staquis™ **as a part of long-term treatment plan** for your appropriate mild-to-moderate AD patients[1,4]

NOW APPROVED
FOR PATIENTS AS YOUNG AS 3 MONTHS[1]

www.pfi.sr/Jzh

The QR code/ URL links to the latest Prescribing Information approved by the Department of Health in Hong Kong and may not be effective and the same as presented in the actual product package.

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*: The specific mechanism(s) by which STAQUIS™ exerts its therapeutic action for the treatment of AD is not well defined [1]

Reference : 1. Staquis™ (crisaborole) Hong Kong Prescribing Information. Pfizer Corporation Hong Kong Limited: Version June 2020. 2. Kaufman MB. Pharmaceutical Approval Update. P.T. 2017; 42(2):90-91. 3. Dong C et al. Treatment of skin inflammation with benzoxaborole phosphodiesterase inhibitors: selectivity, cellular activity, and effect on cytokines associated with skin inflammation and skin architecture changes. J Pharmacol Exp Ther. 2016;358(3):413-422. 4. Eichenfield LF, Call RS, Forsha DW, et al. Long-term safety of crisaborole ointment 2% in children and adults with mild to moderate atopic dermatitis. J Am Acad Dermatol. 2017;77(4):641-649. 5. Bissonnette R, Pavel AB, Diaz A, et. al. Crisaborole and atopic dermatitis skin biomarkers: An intrapatient randomized trial. J Allergy Clin Immunol. 2019;144(5): 1274-1289

PP-STA-HKG-0273 Aug 2022

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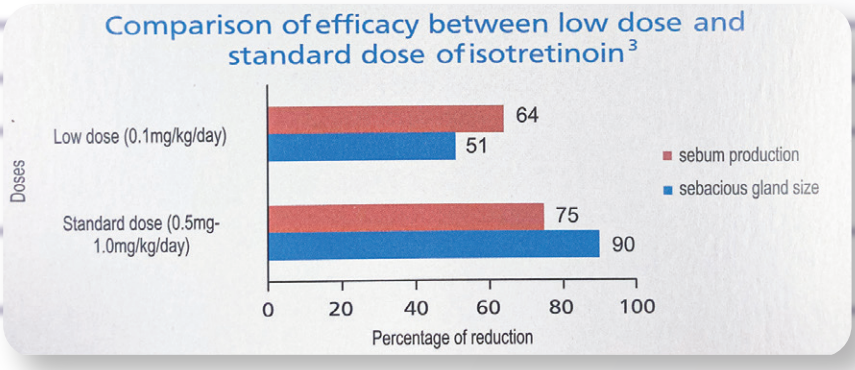
For better titration, management and results

"Oral isotretinoin monotherapy remains the gold-standard treatment for severe acne" [1]

"New developments and future trends represent low-dose long-term isotretinoin regimens" [2]

Benefits of low dose (0.1mg / kg / day) isotretinoin:

- **Efficacy maintained:**



- **Note:**
The low dose treatment in this study only lasted for 6 months, however since isotretinoin is based on cumulative dosage, improvements can be seen as greater if the duration of therapy was longer (e.g. 9 months)

- **High success rate** - 93.9% complete remission or substantial improvement [4]
- **Low relapse rate (3.9%)** [5]
- **Generally well tolerated** - 6.4% discontinued with treatment due to side effects [4]
- **Cost effective**

Reference:
1. Edileia Bagatin Oral isotretinoin : the most promising dermatological off-label uses. Expert Rev.Dermatol.5(6),617-626(2010)
2. Zouboulis C.C, Piquero- Martin J. Update and Future of Systemic Acne Treatment. Dermatology 2003;206:37-53
3. Geissler SE, Michelsen S, Plewig G: Very low dose isotretinoin is effective in controlling seborrhea. J Dtsch Dermatol Ges. 2003 Dec; 1 (12):952-8.
4. Gan, Koh, Jin et al: Isotretinoin is safe and efficacious in Asians with acne vulgaris. Journal of Dermatological treatment. 2012; Early online: 1-5
5. Amichai, Shemer, Grunwald: Low- dose isotretinoin in the treatment of acne vulgaris. J Am Acad Dermatol 2006;54:644-6

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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 improving patient outcomes

Indications

♦ **Adult 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. ♦ **Axial spondyloarthritis (axSpA):** *Ankylosing spondylitis (AS, radiographic axial spondyloarthritis)* Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. *Non-radiographic axial spondyloarthritis (nr-axSpA)* Cosentyx is indicated for the treatment of active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs).[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 2021;237(1):46-55. **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. 2020;34(6):1161-1173. **7.** Novartis data on file. CAIN457F2342 (FUTURE 5): Week 104 Interim Report. April 2019. **8.** Baraliakos X et al. Ann Rheum Dis. 2021;80(5):582-590. **9.** Strober B et al. *J Am Acad Dermatol.* 2017;76(4):655-661. **10.** Cosentyx Hong Kong Prescribing Information. Mar 2021.

Cosentyx®
Important note: Before prescribing, consult full prescribing information. **Presentation:** Secukinumab. Solution for subcutaneous injection in pre-filled syringe or pre-filled pen contain 150 mg or 300 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. **Axial spondyloarthritis (axSpA):** *Ankylosing spondylitis (AS, radiographic axial spondyloarthritis)* Cosentyx is indicated for the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy. *Non-radiographic axial spondyloarthritis (nr-axSpA)* Cosentyx is indicated for the treatment of active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs). **Dosage and administration:** ***Dosage*** **Plaque psoriasis:** The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. **Psoriatic arthritis:** For patients with concomitant moderate to severe plaque psoriasis or who are anti TNFα inadequate responders (IR), the recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. For other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. **Axial spondyloarthritis (axSpA):** *Ankylosing spondylitis (AS, radiographic axial spondyloarthritis)* The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. Each 300 mg dose is given as two subcutaneous injections of 150 mg or one subcutaneous injection of 300 mg. *Non-radiographic axial spondyloarthritis (nr-axSpA)* The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. 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. ♦ **Elderly patients (aged 65 years and over):** No dose adjustment is required. ♦ **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. The solution in the pen must not be shaken. **Contraindications:** ♦ Cosentyx is contraindicated in patients who have/had hypersensitivity reactions to the active substance or to any of the excipients. ♦ Clinically important, active infection (e.g. active tuberculosis) **Warnings and precautions:** ♦ **Traceability:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. ♦ **Infections:** Cosentyx has the potential to increase the risk of infections. Caution in patients with chronic infection or history of recurrent infection. Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. 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. ♦ **Inflammatory bowel disease (including Crohn's disease and ulcerative colitis):** If a patient develops signs and symptoms of inflammatory bowel disease or experiences an exacerbation of pre-existing inflammatory bowel disease, secukinumab should be discontinued and appropriate medical management should be initiated. ♦ **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 (for 150 mg pre-filled syringe/pen only):** The removable cap of the Cosentyx 150 mg pre-filled syringe/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. Secukinumab was administered concomitantly with methotrexate (MTX), sulfasalazine and/or corticosteroids in arthritis studies (including in patients with psoriatic arthritis and ankylosing spondylitis). Caution should be exercised when considering concomitant use of other immunosuppressants and secukinumab. **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, tinea pedis, headache, diarrhea, rhinorrhea, nausea, fatigue. **Uncommon (≥0.1% to <1%):** Oral candidiasis, neutropenia, otitis externa, lower respiratory tract infections, conjunctivitis, inflammatory bowel disease, urticaria. **Rare (≥0.01% to <0.1%):** Anaphylactic reactions, exfoliative dermatitis. **Not known (cannot be estimated from the available data):** Mucosal and cutaneous candidiasis (including oesophageal candidiasis) **Interactions:** Live vaccines should not be given concurrently with Cosentyx. In a study in subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP3A4 substrate). 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 axial spondyloarthritis). **Packs: For 150 mg pre-filled syringe/pen:** Solution in pre-filled syringe: 1's or 2's. Solution in pre-filled pen; 1's or 2's. **For 300 mg pre-filled syringe/pen:** Solution in pre-filled syringe: 1's. Solution in pre-filled pen; 1's. Not all pack sizes are marketed. **Legal classification:** P1S1S3 Last revision: Sep 2021 Ref: EU Mar 2021

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The materials for Cosentyx contained in 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).

For Hong Kong Healthcare Professionals' reference and sole use only.

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NOVARTIS

從身開始，樂得自信。

Elidel® 膚樂得® 無類固醇抗濕疹乳霜

- 有效舒緩濕疹徵狀*，減低復發風險[1,2]
- 適合敏感肌膚間歇性長期使用[1,2]
- 修復外在天然屏障，補充肌膚濕度[3,4]

消炎·補濕·止痕[2-4] | 適合敏感肌膚[1,2]

ELIDEL®
Pimecrolimus Cream 10 mg/g

*適用於對其他外用處方治療沒有充分反應，或不適用的輕度至中度異位性皮膚炎患者。

參考資料：**1.** Elidel® (pimecrolimus) Prescribing Information. Version April 2020. **2.** Luger T, *et al.* Recommendations for pimecrolimus 1% cream in the treatment of mild-to-moderate atopic dermatitis: from medical needs to a new treatment algorithm. *Eur J Dermtol.* 2013;23(6):758-766. **3.** Jensen JM, *et al.* Different effects of pimecrolimus and betamethasone on the skin barrier in patients with atopic dermatitis. *J Allergy Clin Immunol.* 2009;123(5):1124-33. **4.** Ashoff R, *et al.* Skin physiological parameters confirm the therapeutic efficacy of pimecrolimus cream 1% in patients with mild-to-moderate atopic dermatitis. *Exp Dermatol.* 2009; 18(1)24-9.

ELIDEL SUMMARY OF PRODUCT INFORMATION: 1. TRADE NAME: ELIDEL CREAM 1% **2. PRESENTATION:** Each gram of Elidel cream 1% contains 10 mg of pimecrolimus in a whitish cream base of benzyl alcohol, cetyl alcohol, citric acid, mono- and di-glycerides, oleyl alcohol, propylene glycol, sodium cetostearyl sulfate, sodium hydroxide, stearyl alcohol, medium chain triglycerides and water. **3. INDICATIONS:** Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis (eczema) in nonimmunocompromised adults and children 2 years of age and older; Intermittent long-term treatment of emerging and resolving lesions in atopic dermatitis where the use of a topical corticosteroid is not yet warranted, no longer needed, or is inadvisable. **4. DOSAGE:** Apply a thin layer of Elidel 1% to the affected skin twice daily and rub in gently and completely. Elidel 1% cream may be used on all skin areas, including the head and face, neck, and intertriginous areas. **5. CONTRAINDICATIONS:** History of hypersensitivity to pimecrolimus or any of the components of the cream. **6. WARNINGS & PRECAUTIONS:** Elidel should only be applied to areas of eczema. Do not apply to areas affected by acute cutaneous viral infections, cutaneous pre-malignant changes caused by excessive sun exposure or phototherapy, or to areas where skin cancers have been removed. Elidel 1% cream is not recommended in patients with Netherton's syndrome or severely inflamed or damaged skin, and in immunocompromised patients. Use an appropriate antimicrobial agent in the presence of dermatological bacterial or fungal infection, discontinue Elidel 1% cream until the infection has been adequately controlled. Treatment with Elidel may be associated with an increased risk of eczema herpeticum, evaluate the risks and benefits associated with the use of Elidel cream. Avoid exposure to the sun of skin areas treated with Elidel cream. Avoid contact with eyes and mucous membranes. Elidel should not be used in patients receiving phototherapy, in children and adults with weakened immune systems. Application to vaccination sites when local reactions of Elidel persist is not recommended. **7. INTERACTIONS:** Interactions of Elidel cream with systemically administered drugs are unlikely to occur based on its minimal extent of absorption. **8. PREGNANCY AND LACTATION:** There are no adequate data from the use of Elidel cream in pregnant women. Elidel cream should not be used in pregnant women. Caution should be exercised when Elidel 1% cream is to be used in a breastfeeding woman because many drugs are excreted in human milk, and potential serious adverse effects on nursing infants. Elidel 1% cream should not be applied onto the breast for breastfeeding women. **9. SIDE EFFECTS:** Application site burning. Application site reactions (irritation, pruritus, and erythema), skin infections (folliculitis). Reference: HK PI (Apr 2020) Date of preparation: Aug 2021 Identifier number: ELID0821

FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.

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