Hong Kong Dermatology Foundation
香 港 皮 膚 醫 學 慈 善 基 金 會

Hong Kong Dermatology Symposium 2018

28 October 2018 (Sunday)

Prince of Wales Hospital, Shatin

Supporting
Co-organizers

Department of Anatomical & Cellular Pathology, Faculty of Medicine, CUHK
Department of Microbiology, Faculty of Medicine, CUHK

GENVOYA®
(EVG/COBI/FTC/TAF)

GIVE YOUR PATIENTS THE STRENGTH TO POWER THEIR TOMORROW

A single-tablet regimen that contains DESCOVY® (FTC/TAF) to form a complete antiretroviral therapy[1]

Genvoya®
elvitegravir 150mg/cobicistat 150mg/emtricitabine 200mg/tenofovir alafenamide 10mg tablets

THE POWER FOR WHAT'S AHEAD™

Genvoya® showed statistically superior efficacy vs. EVG/COBI/FTC/TDF at Week 144 and non-inferior efficacy at Week 48 and 96 in treatment-naïve patients*

BUILT ON DESCOVY®
emtricitabine
tenofovir alafenamide

COBI, cobicistat; CI, confidence interval; EVG, elvitegravir; FTC, emtricitabine; HIV, human immunodeficiency virus; RNA, ribonucleic acid; TDF, tenofovir disoproxil fumarate.

* GENVOYA® had statistically superior efficacy (HIV-1 RNA<50 copies/mL) vs. EVG/COBI/FTC/TDF at Week 144: 84% vs. 80% (treatment difference 4.2%; 95% CI 0.6 to 7.8). GENVOYA® had non-inferior efficacy vs. EVG/COBI/FTC/TDF at Week 48: 92% vs. 90% (treatment difference 2.0%; 95% CI -0.7 to 4.7) and at Week 96: 87% vs. 85% (treatment difference 1.5%; 95% CI -1.8 to 4.8).

Genvoya® Abbreviated Prescribing Information (Version: HK-OCT15-EU-OCT15+CCDSV5)

Presentation: Green, capsule-shaped, film-coated tablet, debossed with "GSI" on one side and "510" on the other side of tablet. **Indications:** Treatment of adults and adolescents (aged 12 years and older with body weight at least 35 kg) infected with human immunodeficiency virus-1 (HIV-1) without any known mutations associated with resistance to the integrase inhibitor class, emtricitabine or tenofovir. **Dosage:** Adults and adolescents aged 12 years and older, weighing at least 35 kg: One tablet to be taken once daily with food. Elderly: No dose adjustment is required. Renal impairment: No dose adjustment is required in adults or adolescents (aged at least 12 years and of at least 35 kg body weight) with estimated creatinine clearance (CrCl) ≥ 30 mL/min. Genvoya should not be initiated in patients with estimated CrCl < 30 mL/min. Genvoya should be discontinued in patients with estimated CrCl that declines below 30 mL/min during treatment. Hepatic impairment: No dose adjustment is required in patients with mild (Child Pugh Class A) or moderate (Child Pugh Class B) hepatic impairment. Genvoya has not been studied in patients with severe hepatic impairment (Child Pugh Class C); therefore, Genvoya is not recommended for use in patients with severe hepatic impairment. Paediatric population: The safety and efficacy of Genvoya in children younger than 12 years of age, or weighing < 35 kg, have not yet been established. No data are available. Women of childbearing potential/contraception in males and females: Use of Genvoya should be accompanied by use of effective contraception. Pregnancy: Genvoya should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Breast-feeding: Genvoya should not be used during breast-feeding. Fertility: There are no data on fertility from the use of Genvoya in humans. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients; Co-administration with the following medicinal products due to the potential for serious or life-threatening adverse reactions or loss of virologic response and possible resistance to Genvoya: alpha 1-adrenoreceptor antagonists: alfuzosin; antiarrhythmics: amiodarone, quinidine; anticonvulsants: carbamazepine, phenobarbital, phenytoin; antimycobacterials: rifampicin; ergot derivatives: dihydroergotamine, ergometrine, ergotamine; gastrointestinal motility agents: cisapride; herbal products: St. John's wort (Hypericum perforatum); HMG Co-A reductase inhibitors: lovastatin, simvastatin; neuroleptics: pimozide; PDE-5 inhibitors: sildenafil for the treatment of pulmonary arterial hypertension; sedatives/hypnotics: orally administered midazolam, triazolam. **Warnings and Precautions:** While effective viral suppression with antiretroviral therapy has been proven to substantially reduce risk of sexual transmission, a residual risk cannot be excluded. Precautions to prevent transmission should be taken in accordance with national guidelines. Patients co-infected with HIV and hepatitis B or C virus: Safety and efficacy of Genvoya in patients co-infected with HIV-1 and hepatitis C virus (HCV) have not been established. Discontinuation of Genvoya therapy in patients' co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Close monitoring with both clinical and laboratory follow-up for at least several months after stopping treatment should be conducted. Liver disease: Safety and efficacy of Genvoya in patients with significant underlying liver disorders have not been established. Patients with pre-existing liver dysfunction, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. Blood lipids and glucose: Levels of blood lipids and glucose may increase during antiretroviral therapy. Mitochondrial dysfunction: Nucleoside and nucleotide analogues have been demonstrated in vitro and in vivo to cause a variable degree of mitochondrial damage. Any child exposed in utero to nucleoside and nucleotide analogues, even HIV negative children, should have clinical and laboratory follow up and should be fully investigated for possible mitochondrial dysfunction in case of relevant signs or symptoms. Immune Reactivation Syndrome: In HIV infected patients treated with CART, immune reactivation syndrome has been reported. Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders (such as Graves' disease) have also been reported to occur in the setting of immune reactivation. Opportunistic infections: Patients receiving Genvoya may continue to develop opportunistic infections and other complications of HIV infection, and therefore should remain under close clinical observation by physicians experienced in the treatment of patients with HIV associated diseases. Osteonecrosis: Cases of osteonecrosis have been reported particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement. Nephrotoxicity: A potential risk of nephrotoxicity resulting from chronic exposure to low levels of tenofovir due to dosing with tenofovir alafenamide cannot be excluded. Co-administration of other medicinal products: See Contraindications and Drug interactions section in full prescribing information; Genvoya should not be co-administered with other antiretroviral medicinal products; Female patients of childbearing potential should use either a hormonal contraceptive containing at least 30 Qg ethinylestradiol and containing norgestimate as the progestagen or should use an alternative reliable method of contraception. The effect of co-administration with oral contraceptives containing progestagens other than norgestimate is not known and, therefore, should be avoided; Genvoya contains lactose monohydrate, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take Genvoya. **Adverse reactions:** Dizziness has been reported during treatment with Genvoya. The most frequently reported adverse reactions in clinical studies were nausea, diarrhoea and headache. Autoimmune disorders (such as Graves' disease) have been reported. **Drug interactions:** Genvoya should not be co administered with other antiretroviral medicinal products. Genvoya should not be administered concomitantly with medicinal products containing tenofovir disoproxil (as fumarate), lamivudine or adefovir dipivoxil used for the treatment of HBV infection. Genvoya should not be co-administered with medicinal products that are primarily metabolised by CYP3A. Potential interactions between the components of Genvoya and the following co-administered medicinal products: Antifungals (ketoconazole/elvitegravir, itraconazole, voriconazole, posaconazole, fluconazole); Antimycobacterials (rifabutin/ elvitegravir/cobicistat); Anti-hepatitis C virus medicinal products (telaprevir/elvitegravir/cobicistat, boceprevir); Macrolide antibiotics (clarithromycin, telithromycin); Anticonvulsants (carbamazepine/elvitegravir/cobicistat); Glucocorticoids: All corticosteroids excluding cutaneous products (betamethasone, budesonide, fluticasone, mometasone, prednisone, triamcinolone); Antacids (magnesium/aluminium-containing antacid suspension/elvitegravir /ritonavir); Food supplements (mutivitamin supplements); Oral anti-diabetics (metformin); Oral contraceptives (norgestimate/ethinylestradiol/elvitegravir/cobicistat); Antiarrhythmics (digoxin, disopyramide, flecainide, systemic lidocaine, mexiletine, propafenone); Anti-hypertensives (metoprolol, timolol, amlodipine, diltiazem, felodipine, nicardipine, nifedipine, verapamil); Endothelin receptor antagonists (bosentan); Anticoagulants (warfarin, dabigatran); Inhaled beta agonist (salmeterol); HMG CO-A reductase inhibitors (atorvastatin, pitavastatin, lovastatin, simvastatin); Phosphodiesterase type 5 (PDE-5) inhibitors (sildenafil, tadalafil, vardenafil) Antidepressants (tricyclic antidepressants, trazodone, selective serotonin reuptake inhibitors, escitalopram); Immunosuppressants (ciclosporin, sirolimus, tacrolimus); Sedatives/hypnotics (buspirone, clorazepate, diazepam, estazolam, flurazepam, lorazepam, triazolam, zolpidem, orally administered midazolam/tenofovir alafenamide, intravenously administered midazolam/tenofovir alafenamide); Anti-gout (colchicine).
Before prescribing, please consult full prescribing information which is available upon request.

References: 1. Genvoya Prescribing Information (Version: HK-OCT15-EU-OCT15+CCDSV5) 2. Arribas JR, et al. J Acquir Immune Defic Syndr 2017; 75(2): 211–218
Further information can be provided upon request.

HKGEN050_v1.0 12/13/2017

GILEAD
Advancing Therapeutics. Improving Lives.

Gilead Sciences Hong Kong Limited
Room 2603, 26th Floor, Hysan Place,
500 Hennessy Road, Causeway Bay, Hong Kong
Tel: +852 3129 2000 Fax: +852 2856 2611

Welcome Message

This Symposium serves to bring together academicians and specialists of different subspecialties who all share a common interest in skin and sexually transmitted diseases.

Over the years, our function has gained recognition and popularity in the medical field. It is now a major annual event in the local community. Each year, the Symposium attracts well over 300 participants.

This year, we are very glad to have invited several specialists in other medical fields to share with us their expertise. Prof. Tong KC NG from the department of microbiology, CUHK will talk to us on "Antibiotic resistance in dermatology; Dr. Dicky WS CHUNG, consultant psychiatrist, will highlight to the audience "Relevance of psychiatry in skin problems"; Dr. Priscilla CH WONG, rheumatology specialist, will teach us how to recognize and manage psoriatic arthritis. Last but not the least, Prof. Rosaline CY HUI from Taipei Chang Gung Memorial Hospital will elaborate to us on the cardiovascular risk of patients with psoriasis.

Among local dermatologists, I am very much indebted to Dr. KWAN Chi Keung, Dr. Steven KF LOO, Dr. Bessie BS TONG, Dr. Stanley CK HO, Dr. Erica KY YAU, Dr. Mildred YM WAT and Dr. Gavin J CHAN who will share their experience with us in the management of various common and important skin diseases. The titles of their talk are listed in the scientific program. I would also like to express my gratitude to Dr. LO Kuen Kong, Dr. William YM TANG, Dr. LEUNG Chi Yan and Dr. LEE Tze Yuen for their help in chairing the sessions.

Finally I would like to thank our sponsors as well as the audience who have been supporting this function all these years and contributed to its success.

I wish you enjoy the meeting and learn some useful knowledge for your practice.

Dr. LUK Nai Ming
Organizing Committee

Organizing Committee

Prof. Paul KS CHAN
Dr. Tony KC NG
Dr. LUK Nai Ming
Prof. TO Ka Fai

Moderators and Faculty

Dr. Gavin J CHAN
Dr. Stanley CK HO
Dr. KWAN Chi Keung
Dr. LEUNG Chi Yan
Dr. Steven KF LOO
Dr. Tony KC NG
Dr. Bessie BS TONG
Dr. Priscilla CH WONG
Dr. Dicky WS CHUNG
Prof. Rosaline CY HUI
Dr. LEE Tze Yuen
Dr. LO Kuen Kong
Dr. LUK Nai Ming
Dr. William YM TANG
Dr. Mildred YM WAT
Dr. Erica KY YAU

We would like to thank the following sponsors for their generous support

Scientific Program

Time	Program	Faculty
8:30	Registration	
8:50	Opening Remarks	
	Moderator - Dr. William YM TANG	
9:00	Low level light / laser therapy in dermatology	Dr. LUK Nai Ming
9:30	Safety of biologics in treatment of psoriasis	Dr. Bessie BS TONG
10:00	Atopic dermatitis : pearls in management	Dr. Mildred YM WAT
10:30	Tea Break	
	Moderator - Dr. LO Kuen Kong	
11:00	Antibiotic resistance in dermatology	Prof. Tony KC NG
11:30	Atypical Mycobacterium skin infections	Dr. Stanley CK HO
12:00	Sexually Transmitted Infections - challenges ahead	Dr. KWAN Chi Keung
12:30	What dermatologists need to know about psoriatic arthritis	Dr. Priscilla CH WONG
13:00	Luncheon Symposium Moderator - Dr. LEUNG Chi Yan / Dr. LUK Nai Ming Beyond clear skin: Psoriasis and Cardiovascular Diseases Speaker: Prof. Rosaline CY HUI	
	Moderator - Dr. LEE Tze Yuen	
14:00	Cutaneous manifestations of child abuse	Dr. Erica KY YAU
14:30	Relevance of psychiatry in skin problems	Dr. Dicky WS CHUNG
15:00	Update in the management of melasma	Dr. Gavin J CHAN
15:30	Management of acne scars	Dr. Steven KF LOO
16:00	End of Program	

Academic Accreditation

Participants joining all symposium sessions will be awarded Continuing Medical Education (CME), Continuing Nursing Education (CNE) and/or Continuing Professional Development (CPD) points from the following academic institutions. Please sign in at the foyer of the Postgraduate Education Centre.

College/Program	CME/CPD Points Awarded	CME/CPD Points Awarded
	28 Oct	Category
Anaesthesiologists	5.5	Non-ana passive
Community Medicine	5	
Dental Surgeons	5.5	Cat. B
Emergency Medicine	5.5	PP
Family Physicians	5	Cat. 5.2
Obstetricians & Gynaecologists	Pending	Non-OG
Ophthalmologists	2.75	PP
Otorhinolaryngologists	3	Cat. 2.2
Paediatricians	6	Cat. E
Pathologists	6	PP
Physicians	5.5	
Psychiatrists	5.5	PP/OP
Radiologists	5.5	Cat. B
Surgeons	5.5	Passive
MCHK CME Programme	Pending	Accredited by CUHK
Nursing Council of Hong Kong	5.5	

Low level light / laser therapy in dermatology

LUK Nai Ming

Hong Kong Dermatology Foundation

Low Level light / laser therapy (LLLT) for dermatological conditions has gained popularity recently. Commercial devices for treating acne vulgaris, wrinkles, herpes labialis and androgenetic alopecia are widely available.

The mechanism of LLLT is thought via photobiomodulation (PBM) which is defined by the use of non-ionizing radiation, (e.g. low level laser or light emitting diode) to induce biological effects such as anti-inflammatory, immunomodulatory or anti-apoptotoic. The process does not involve thermal or ablative means. In essence, the red or near infra-red radiation are absorbed by the Cytochrome C Oxidase in the mitochondria (the chromophore) resulting in the increased release of ATP, Nitric oxide and ROS (reactive oxygen species) and via vasodilation or increased nuclear transcription to mediate these effects. Important parameters in LLLT treatment include appropriate wavelength of electromagnetic radiation, the irradiance of the light source (Medicine) and the total fluence used (Dose).

In the presentation, the LLLT trials on herpes labialis, ophthalmic herpes zoster, psoriasis, chronic venous ulcer, radiation dermatitis, male pattern baldness and wrinkles will be presented.

The efficacious of LLLT is very variable. However, no serious adverse effects has been reported.

In conclusion, LLLT is a safe treatment with variable efficacy, the exact mechanism of action needs further clarification. It can be used as an adjuvant therapy or when conventional treatment is contraindicated.

Safety of biologics in treatment of psoriasis

Dr. Bessie BS TONG

Private Dermatologist

Psoriasis is a chronic immune-mediated inflammatory disorder involving skin, joints or both, often associated with several metabolic and non-metabolic comorbidities. In the past, when only topical treatment, phototherapy and oral systemic therapy were available, some patients could merely obtain suboptimal control of the disorder because of insufficient effectiveness and adverse effects of the traditional therapies.

Over the last decade, the development of biologic therapies targeting selective key immune pathways has revolutionized the treatment of patients with moderate to severe psoriasis. Despite biologics have shown excellent efficacy, safety concerns have been raised. In some studies, these biologic agents have demonstrated a favorable safety profile without evidence of cumulative organ-specific toxicity. However, several contradictions exist in literature. In addition, there are some adverse events of special interest that require monitoring when treating with biologics, including infections such as tuberculosis, hepatitis B & C virus reactivation; major adverse cardiovascular events, and malignancies, to name but a few. The objective of this presentation is to review the safety profile of the biologics for treatment of psoriasis.

Atopic dermatitis : pearls in management

Dr. Mildred YM WAT

Social Hygiene Service, Centre for Health Protection, Hong Kong

Atopic dermatitis is one of the most common chronic inflammatory skin diseases causing a great physical and psychological burden to patients and their caregivers. With the better understanding of the science of atopic dermatitis, a change in treatment paradigm advocated.

It is now believed that atopic dermatitis is due to the interplay between barrier defect causing increase permeability, disruption in microbiome and shift in adaptive immunity towards TH2 immune response. Current advocates on early and aggressive barrier repair, correction in dysbiosis and newer agents targeting on specific inflammatory cytokines are bringing new hope to patients suffering from this life-ruining disease. Researchers are even looking at whether early barrier repair can reduce sensitization and halt the progression to other allergic co-morbidities.

However, even with the emergence of all these newer agents, the key to success is still to empower the patients and their care-givers with knowledge about their disease course and triggers, provide them with clear and easy-to-follow management strategies (Eczema Action Plan), acknowledge their fear and provide appropriate guidance on topical steroid use and allow easy access to care and medication when flare occurs.

Antibiotic resistance in dermatology

Dr. Tony KC NG

Department of Microbiology, The Chinese University of Hong Kong

Since the discovery of penicillin by Alexander Fleming in 1928 and its widespread use since the 1940s, antibiotic has become an indispensible part of our weapons for treating bacterial infections. Bacteria are clever to evolve or select themselves to fight against the antibiotics while pharmaceutical field works hard to overcome bacterial resistance by developing new antibiotics. Oral and topical antibiotics are also among the most commonly prescribed therapies in dermatological practice. The heavy use of antibiotics in clinical settings as well as in animal husbandry has promoted the emergence of resistance and this has much impact on the treatment of infections in general and has cause a genuine global concern. There is no exception in dermatology that common bacteria causing dermatological infections are getting more resistant. Among these are Staphylococcus aureus, Streptococcus pyogenes, Propionibacterium acnes as well as many other bacterial species causing dermatological infections in other healthcare settings. Sensible use of antibiotics (such as in acne vulgaris and other common skin structure infections) with a background of emerged or emerging resistance problems in common dermatological situations (such as CA-MRSA, resistance in Propionibacterium acnes and resistance of commonly used antibiotics in dermatological settings) should be promoted.

Atypical Mycobacterium skin infections

Dr. Stanley CK HO

Social Hygiene Service, Centre for Health Protection, Hong Kong

Atypical mycobacteria are defined as mycobacteria other than M. tuberculosus or M. leprae. The most important atypical mycobacterial infections affecting the skin are M. marinum, M. fortiutum, and M. chelonae. Although not as well-known as M. tuberculosus or M. leprae, these infections can lead to significant morbidity, particularly in immunocompromised patients. The recent fatal case of M. abscessus infection following an intravenous procedure at a beauty parlour highlights the potential hazards of these treatments. This lecture aims to provide a brief discussion of these infections.

Sexually Transmitted Infections - challenges ahead

Dr. KWAN Chi Keung

Special Preventive Program

Traditionally, the phrase of "Sexually Transmitted Diseases (STDs)" was used. Now, more authorities including World Health Organization (WHO) prefer the phrase of "Sexually Transmitted Infections (STIs) because majority of STIs may not necessarily have symptoms. STI is often being neglected not only by clinicians, patients, researchers but also governments. WHO estimated that more than 1 million STIs are acquired every day worldwide. Social Hygiene Clinic also had over 150,000 attendances in 2016. This is definitely a challenge.

Antibiotic resistance is another challenge especially in Neisseria gonorrhoeae (NG) and Mycoplasma genitalium (MG) infection. According to previous experience in Social Hygiene Clinic, the antibiotic treatment for NG infection is needed to be changed every 10 to 15 years owing to the development of antibiotic resistance. MG is another STI that frequently encounters antibiotic resistance. It is commonly resistant to macrolides and even quinolones. Besides its resistance, the lack of diagnostic test of MG in public sector is another STI challenge.

Enteric diseases such as hepatitis A virus infection, giardiasis, entamoba histolytica, shigellosis and so on, are classically acquired through ingestion of contaminated food or water. However, more and more reports suggested these enteric pathogens can also be transmitted through sexual activities involving fecal-oral contact, such as oral-anal, oral-genital and anal-genital intercourse especially in MSM. These are called "Sexually Transmitted Enteric Infections (STEI)". It is not a new entity and has been reported in 1970s. STEI is not far away but it has actually happened in Hong Kong recently. There was an outbreak of hepatitis A virus infection just in 2017 and clustered mainly in HIV positive MSM.

Challenge never ends. As a clinician interested in STI, we should widen our horizon and prepare ourselves to face new and different challenges ahead from all possible aspects.

What dermatologists need to know about psoriatic arthritis

Dr. Priscilla CH WONG

Department of Medicine & Therapeutics, The Chinese University of Hong Kong

Psoriasis constitutes a significant proportion of a dermatologist's workload, as it is a common (with a prevalence of approximately 2% of the population) and an incurable disease. Dermatologists are competent in the management of the skin component of the condition, yet many may not be so familiar with the diagnosis, treatment or indications for referral to a rheumatologist of co-existent psoriatic arthritis (PsA).

Psoriatic arthritis (PsA) is a heterogenous multifaceted inflammatory arthritis associated with psoriasis. In addition to peripheral arthritis, patient with PsA may develop spondylitis, dactylitis, enthesitis, nail disease as well as extra-articular features common to the spondyloarthropathies. Early diagnosis and therapeutic intervention are crucial for limiting PsA progression, preventing disability and improving the quality of life for the patients. Dermatologists are in a privileged and crucial position to detect PsA early and to orchestrate the management of both psoriasis and PsA.

Currently the management of patients with PsA in the dermatology setting is widely variable. In this talk, we will discuss the clinical manifestations, classification criteria, clinical assessments and the state-of-the-art treatment of PsA. We will also provide practical recommendations for the management of patients with PsA in the dermatology setting including early diagnosis and treatment.

Beyond clear skin: Psoriasis and Cardiovascular Diseases

Prof. Rosaline CY HUI

Chang Gung Memorial Hospital, Taipei

The treatment of psoriasis has improved with the advent of biologic therapies because these drugs, especially the new ones, are highly efficacious so patients can have the opportunity to achieve complete or almost complete clearance on the skin.

However, since psoriasis is a lifelong disease most patients will require a long-term management so we need not only effective treatments but also sustainable therapies which bring long lasting complete treatment with a favorable safety profile. In this lecture we will see the psoriasis treatment data not only from clinical trials but also from real world evidence.

Moreover, psoriasis disease is more than just skin plaques, it can present with several clinical manifestations that can have several impact on quality of life and daily activities of patients and it can be associated with systemic comorbidities, such as cardiovascular disease and metabolic disorders.

Which are the pathological aspects of these diseases? How to manage psoriasis and comorbidities? We will focus on these topics with the purpose of providing an updated and advanced management for our patients.

Cutaneous manifestations of child abuse

Dr. Erica KY YAU

Private dermatologist

Dermatologic injury is the most common and recognizable sign for physical child abuse. Medical professionals have obligation to identify and initiate investigations for any solid suspicion of child abuse.

It is always challenging to differentiate signs of child abuse from dermatological conditions that mimic intentional injury. Common mimickers include bullous impetigo, Mongolian spots, Henoch-Schonlein purpura. The situation can be further complicated when history from patients or caregivers is misleading. Whenever possible, the child should be interviewed independently for the cause of the injury. It is important to take comprehensive history from the caregivers for their description of the alleged abuse. Concern should arise if the history is not consistent with the injury or the child's developmental level. To identify cases of child abuse, a good understanding of patterns, locations and appearance of the signs of maltreatment is imperative. In addition, knowledge of normal developmental presentation of accidental injury during infancy and childhood is also important.

To safeguard the welfare of children, physicians should always be vigilant of child abuse as the life of victim depends on us recognizing the signs. For any reasonable suspicion of child abuse, it is crucial to report promptly to appropriate authorities to protect the children from further injury.

Relevance of psychiatry in skin problems

Dr. Dicky WS CHUNG

Tai Po Hospital

Although both skin and brain originate embryonically from ectoderm, later becoming the outermost and inner parts of our body, their disorders obviously are manifested differently. The dermatological disorders are conspicuous, concrete and objective, whereas psychiatric disorders are inner, subtle and subjective. However, they share some commonalities, i.e. many being a chronic relapsing illness attached with strong social stigma, and exacerbated by stress. They are also interrelated, either as a presenting complaint of, a sequalae of the partnering disorder, or reciprocally connected pathophysiologically. These relationships can be categorized into 1) primary psychiatric disorders presenting as dermatological complaints, 2) secondary psychiatric disorders as a morbid psychological reaction to troublesome skin disorders and 3) psychophysiologic disorders, in which mood altering the severity of skin disorders. In view of increasing findings on inflammatory reactions in psychiatric disorders, how the brain and skin react to stress through a common neuro-endocrine-immunological process is discussed. In dermatological setting, the psychiatric approaches to manage primary psychiatric disorders, like delusional infestation, body dysmorphic disorder, impulse control disorders and obsessive-compulsive disorder, are described. Since most of these patients are unwilling to be referred to see psychiatrists, dermatologists or primary care doctors should equip themselves to be able to identify them early and are more capable of treating them while the illness still at early stage.

Update in the management of melasma

Dr. Gavin J CHAN

Private Dermatologist

Melasma is a common acquired pigmentary disorder characterized by pigmentation mostly involving sun-exposed areas such as the forehead, cheeks and upper lip. Its etiology is still unknown, though sun-exposure, hormonal activity and genetics are thought to be the most important factors. Management of melasma remains challenging, and involves education, avoidance of exacerbating factors, and treatment with monotherapies or combination therapy. An updated review of the management of melasma will be presented.

Management of acne scars

Dr. Steven KF LOO

Private dermatologist

Acne vulgaris has a prevalence of over 90% among adolescents and often continues to adulthood with a significant psychosocial impact. Scarring often results early with a substantial negative impact on overall patient functional and social well-being. Acne scars could be classified into atrophic, hypertrophic or keloidal type, while atrophic scars are further subdivided into icepick, boxcar, and rolling scars. These various types of scars can additionally be erythematous, hyperpigmented or hypopigmented.

Common treatment modalities for different acne scar type including topical dermaceuticals, laser and other energy based devices (resurfacing, pigment, vascular and collagen remodelling devices), subcision surgery, fillers injection etc. will be discussed.

A customized and combination treatment based on the different scar type is needed for optimal treatment outcomes.

ELIDEL®
Pimecrolimus Cream 10mg/g

Why a new treatment algorithm?

- **TCS are still a main therapy for AD treatment, but they have some limitations including:**
  - Skin atrophy[1]
  - Damage of the skin barrier[2]
  - Systemic absorption[1]
  - Increased skin infections[3]
  - HPA axis suppression[4]
- **Pimecrolimus 1% TCI is now proven as effective as TCS (Petite Study) with clear benefits and advantages over TCS**
- **Pimecrolimus 1% TCI has to be re-evaluated and repositioned in the AD treatment**

New treatment algorithm for mild to moderate AD: an European Consensus[5]

A group of 12 international experts in AD management developed a new AD treatment algorithm (EJD,2013[5]) based on literature review and their own experience

ACUTE MILD-TO-MODERATE AD
Children, adolescents and adults

INFECTED AD
(odour. oozing, pustules, …)

- Clean the skin properly to remove crusts and/or scales
- Antibacterial/antiseptics or systemic antibiotics as necessary
- TCS until signs and symptoms disappear

First line therapy :

- Clean the skin properly to remove crusts and/or scales
- First 3-4 days : TCS twice daily until improvement
- Then : alternate TCS and pimercolimus 1% once daily or use pimecrolimus alone twice daily
- Emollients as often as necessary

Upon improvements of eczema and pruritus :

- Pimecrolimus 1% twice daily to all affected areas at the first signs or symptoms of AD and until their disappearance
- Emollients as often as necessary

CONTINUOUS MILD AD
Children, adolescents and adults

First line therapy

- Pimecrolimus 1% twice daily to all affected areas at the first signs or symptoms of AD and until their disappearance
- Emollients as often as necessary

COMPLETE RESOLUTION OF LESIONS

MAINTENANCE THERAPY
→ To prevent flare-ups and reduce need for TCS :

- Pimecrolimus 1% once daily 7 days a week up to 3 months or less frequently (depending on physician advice*) to the previously affected skin
- Emollients as often as necessary on normal-appearing skin

Stop Pimecrolimus 1% :
Emolients as often as necessary

At first sign of flare-up :
Pimecrolimus 1% twice daily until disappearance of signs and symptoms

TCS = Topical corticosteroids

TCI = Topical calcineurin inhibitors

Conclusions

"Pimecrolimus 1% cream may be considered the drug of choice for the treatment of patients with mild-to-moderate AD in children as well as in adults and particularly in sensitive skin areas."

Mylan Pharmaceutical Hong Kong Limited
Tel : (852) 2649 9565

Mylan

1. Hengge UR et al. J Am Acad Dermatol 2006; 2. Jensen JM et al. Allergy 2012; 3. Luger TA, et al. J Dermatolog Treat 2004; 4.Gilbertson EO et al. J Am Acad Dermatol 1998. 5. Luger T et al. Eur J Dermatol 2013

TEVA | Actavis GENERICS

THE WORLD'S LARGEST MEDICINE CABINET

A Full Spectrum of

Generic Drugs

1000+ generic molecules marketed around the world[1]

Specialty Drugs

27 new products to be launched in 2015-2019[2]

Biologics

Novel biologics focused on CNS, pain disorders and respiratory[3]

CNS=central nervous system.

References: 1. Teva. Generics R&D. http://www.tevapharm.com/research_development/rd_integrated/generics/. Accessed Mar 2018. 2. Teva. Annual Report 2014. http://www.tevapharm.com/files/about/lobby/annual_report_2014.pdf. Accessed Mar 2018. 3. Teva. Integrated R&D. http://www.tevapharm.com/research_development/rd_integrated/biologic/. Accessed May 2018.

Room 2303, 23/F, Mira Place Tower A,
132 Nathan Road, Tsim Sha Tsui,
Kowloon, Hong Kong
Tel (852) 3188 4288 Fax (852) 2663 2662

COB-HK-00008
4iC_519

AERIUS®
desloratadine

Accepted by U.S. Federal Aviation Administration (FAA)[1]

Effectively relieve symptoms associated with allergic rhinitis, urticaria#, chronic idiopathic urticaria^

- **Fast onset of symptom relief[2] ***
- **Efficacious[3,4]**
- **27-hour half-life[5]**
- **Less-sedating & Less-drowsy[6] †**
- **No interaction with grapefruit juice[7]**
- **Convenient syrup formulation for patients as young as 6-month-old[8] ‡**
- **No impairment of driving performance vs placebo[9] ****

Indication of Aerius Tablet

^ Indication of Aerius Syrup

* Efficacy data were from four post marketing surveillance studies involving 77,880 subjects using oral desloratadine 5mg tablet daily for Seasonal Allergic Rhinitis and Chronic Idiopathic Urticaria. Onset of action results were subject-rated from post hoc analysis of these studies (n=17,575) where subjects had previously received monotherapy with another second generation antihistamine (cetirizine, fexofenadine, loratadine or mizolastine). AERIUS® shows fast onset of symptom relief compared with other second generation antihistamines rated by 67% of subjects.

† Risk of sedation and drowsiness is lower than levocetirizine ($P < 0.0001$) in patients with allergic rhinitis without asthma/wheezing.

‡ AERIUS® Syrup is indicated for the relief of the nasal and non-nasal symptoms of perennial allergic rhinitis in patients 6 months of age and older.

**In a driving performance & psychomotor performance study, at therapeutic dose of 5mg, no significant difference weree noted between desloratadine & placebo in standard deviation of lateral position (SDLP), one of the parameter to measure driving performance.

INDICATIONS:
AERIUS® Tablets:
AERIUS® Tablets are indicated for the relief of symptoms associated with allergic rhinitis (AR), and urticaria.
AERIUS® Syrup:
Seasonal Allergic Rhinitis: AERIUS® Syrup is indicated for the relief of the nasal and non-nasal symptoms of seasonal allergic rhinitis in patients 2 years of age and older.
Perennial Allergic Rhinitis: AERIUS® Syrup is indicated for the relief of the nasal and non-nasal symptoms of perennial allergic rhinitis in patients 6 months of age and older.
Chronic Idiopathic Urticaria: AERIUS® Syrup is indicated for the symptomatic relief of pruritus, reduction in the number of hives and size of hives, in patients with chronic idiopathic urticaria 6 months of age and older.

DOSAGE:
AERIUS® Tablet, Desloratadine (5mg/Tab)
Adults and adolescents (>=12 years of age): One AERIUS® 5mg film-coated tablet once a day for the relief of symptoms associated with allergic rhinitis (including intermittent and persistent allergic rhinitis) and urticaria. For oral use.
AERIUS® Syrup, Desloratadine (0.5mg/ml)
Adults and adolescents (>=12 years of age): 10ml (5mg) AERIUS® syrup once a day, regardless of mealtime.
Children 6 through 11 years of age: 5ml (2.5mg) AERIUS® syrup once a day, with or without a meal.
Children 1 through 5 years of age: 2.5ml (1.25mg) AERIUS® syrup once a day, with or without a meal.
Children 6 months through 11 months of age: 2ml (1.0mg) AERIUS® syrup once a day, with or without a meal.

CONTRAINDICATIONS:
Hypersensitivity to the active substance or to any of the excipients.

PRECAUTIONS:
AERIUS® Tablets: Efficacy and safety of AERIUS® Tablets in children under 12 years of age have not been established. Effect on ability to drive and use machines: No overall effects on the ability to drive and use machines have been observed.
AERIUS® Syrup: Efficacy and safety of AERIUS® Syrup in children under 6 months of age have not been established. Effect on ability to drive and use machines: No overall effects on the ability to drive and use machines have been observed.
USAGE DURING PREGNANCY AND LACTATION: No teratogenic or mutagenic effects were observed in animal trials with desloratadine. Since no clinical data on exposed pregnancies are available with desloratadine, the safe use of AERIUS® Tablets and AERIUS® Syrup during pregnancy has not been established. AERIUS® Tablets and AERIUS® Syrup are not to be used during pregnancy unless the potential benefits outweigh the risks. Desloratadine is excreted into breast milk; therefore the use of AERIUS® Tablets and AERIUS® Syrup are not recommended in breast-feeding women.
Before prescribing *AERIUS®*, please consult the full prescribing information.
AERIUS® is contraindicated in patients who are hypersensitive to the active substance or to any of the excipients.
AERIUS® Tablet: In clinical trials in a range of indications including AR and CIU, at the recommended dose of 5mg daily, undesirable effects with AERIUS® Tablets were reported in 3% of patients in excess of those treated with placebo. The most frequent adverse events reported in excess of placebo are: fatigue (1.2%), dry mouth (0.8%), and headache (0.6%).
AERIUS® Syrup: The overall incidence of adverse events a in children 2 through 11 years of age was similar for AERIUS® Syrup and the placebo groups. In infants and toddlers aged 6 to 23 months, the most frequent adverse events reported in excess of placebo were diarrhea (3.7%), fever (2.3%) and insomnia (2.3%). At the recommended dose of 5 mg daily, undesirable effects with AERIUS® Tablets were reported in 3% of patients in excess of those treated with placebo. The most frequent adverse events reported in excess of placebo were fatigue (1.2%), dry mouth (0.8%), and headache (0.6%).

References:
1. Federal Aviation Administration. (2018). *Guide for Aviation Medical Examiners*. 1-470. **2.** Results were rated by subjects using oral Desloratadine 5mg tablet daily for Seasonal Allergic Rhinitis and Chronic Idiopathic Urticaria, where subjects had previously received monotherapy with another second generation antihistamine (Cetirizine, Fexofenadine, Loratadine or Mizolastine). Bachert, C., & Maurer, M. (2010). Safety and Efcacy of Desloratadine in Subjects with Seasonal Allergic Rhinitis or Chronic Urticaria. Clinical Drug Investigation, 30(2):109-122. **3.** Bousquet, J., & Bachert, C. (2009). Efcacy of desloratadine in intermittent allergic rhinitis: A GA 2 LEN study. Allergy, 64: 1516-1523. **4.** Bousquet, J., & Bachert, C. (2010). Efcacy of Desloratadine in Persistent Allergic Rhinitis – A GA2 LEN Study. Int Arch Allergy Immunol International Archives of Allergy and Immunology, 153: 395-402. **5.** Simons, F. (2004). Advances in H 1 -Antihistamines. New England Journal of Medicine N Engl J Med, 351(21): 2203-2217. **6.** Layton, D., & Wilton, L. (2006). Comparison of the Risk of Drowsiness and Sedation between Levocetirizine and Desloratadine. Drug Safety, 29(10) 897-909. **7.** Banfield, C., & Gupta, S. (2002). Grapefruit Juice Reduces the Oral Bioavailability of Fexofenadine But Not Desloratadine. Clinical Pharmacokinetics, 41(4) 311-318. **8.** Package Insert AERIUS Syrup. **9.** Vuurman E, et al. Effects of desloratadine, diphenhydramine, and placebo on driving performance and psychomotor performance measurements. *Eur J Clin Pharmacol* (2004) 60: 307–313.

Bayer

拜耳醫療保健有限公司
Bayer HealthCare Limited
14TH FLOOR, OXFORD HOUSE, TAIKOO PLACE,
979 KING'S ROAD, QUARRY BAY, HONG KONG
Tel: (852) 2814 5299 Fax: (852) 3526 4751

LHK.MKT.09.2018.2358

Introducing Physiogel
Calming Relief AI Restoring Lipid Balm

PHYSIOGEL
HYPOALLERGENIC

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

EXCLUSIVE FOR PHYSICIAN CLINICS

Non-comedogenic
Clinically Tested
by dermatologists
Suitable for use on very dry skin, including skin prone to atopic dermatitis

Proven results:

After 1 hour of application

76%* reduction in itch

73%* reduction in skin irritation

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

After 4 weeks

85%** reduction in itch

**mean subject rating (n=44) *versus* baseline after 4 weeks twice daily use

After 4 weeks

68%*** reduction in redness

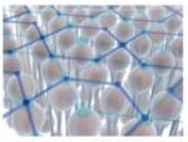
***Subject-assessed redness (n=44) compared to baseline

Reference:
1. Cosmetic study in subjects (n=45) with moderately dry to very dry skin with signs and symptoms of redness, irritation, infl ammation or itch. 2. Lambert DM *et al*. The Palmitoylethanolamide Family: A New Class of Anti-Infl ammatory Agents? Curr Med Chem 2002; 9: 663- 74. 3. PEA *in-vitro* study. 4. Wang X. *et al*. Anti-infl ammatory and photoprotective effects of palmitoylethanolamide and RHE, Sic Inv Dermat. May 2015
±PEA, palmitoylethanolamide.

BioMimic Technology

Scientifically formulated with:

Advanced Physiogel BioMimic Technology: a complex that mimics the skin's protective lipid barrier. The unique structure and composition of this technology helps strengthen and repair the skin's barrier function



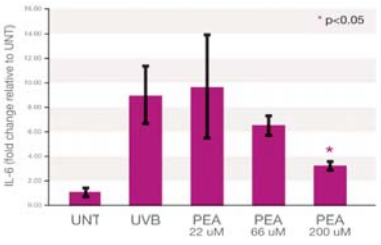
High lipid content: 40% essential lipids

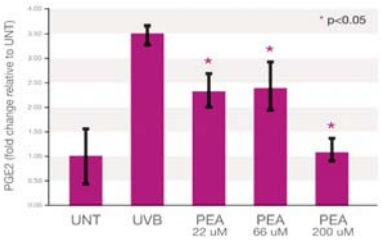
Palmitamide MEA (PEA)±: naturally occurring fatty acid to help rapidly soothe and relieve skin that is very dry, irritated and reactive

Results from new *in-vitro* studies with PEA show potential anti-irritant effects[2-4]

Inhibition of UVB-induced pro-inflammatory mediators (IL-6 and PGE2)

PEA reduced the expression of UVB induced pro-inflammatory mediators (IL-6 and PGE2) in skin[4]





GlaxoSmithKline Consumer Healthcare (Hong Kong) Limited
23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong
Tel: 3189 8989 Fax: 3189 8931 www.gsk.com.hk

CHHK/CHPHY/0051/17(!) (05/2020)

Stiefel Skin Science Solutions

TOTAL DERMATOLOGY SOLUTIONS

TAISHO PHARMACEUTICAL (HK) LTD

Antifungal

Antibiotic

Corticosteroid

Nasal Decongestant

Skin Care

Anti Acne

Antipruritic

Scabicide

Probiotic

Enquiry: 2710 9618 2710 9615 enquiry@hktaisho.hk www.taisho.hk

ONCE-DAILY soolantra®

(IVERMECTIN) 10 mg/g CREAM

With an innovative dual MoA that works faster and more effectively at bringing patients to 'clear' (IGA 0) than metronidazole 7.5 mg/g cream*†[1-6]

Once-daily SOOLANTRA® (ivermectin)10 mg/g Cream, for patients with inflammatory lesions of rosacea (papulopustular)[1]

1. SOOLANTRA® (ivermectin) 10 mg/g Cream Summary of Product Characteristics. 09 May 2017.
2. Taieb A, *et al. Br J Dermatol* 2015;172:1103–1110.
3. Ci X, *et al. Fundam Clin Pharmacol* 2009;23:449–455.
4. Merck Sharp & Dohme Corp. Stromectol® (ivermectin) Prescribing Information. 2010.
5. Schaller M, *et al. J Eur Acad Dermatol Venereol* 2017; In press.Doi: 10.1111/jdv.14437.
6. Stankiewicz M, *et al. Vet Immunol and Immunopathol* 1995;44:347–358.

GALDERMA
Tel (852) 2824 0333 Fax (852) 2827 7760

SOO-DA001-0818

STELARA® (Ustekinumab)

is strongly recommended as a first-line biologic agent to adults with psoriasis who fulfilled the criteria for biologic therapy.[1]

Sustained Control

Persistence with Stelara® is consistently shown to be better vs other biologics.[2-4]

Favorable Safety Profile

No increased risk of malignancy, MACE, serious infections and mortality.[5]

Convenient Dosing Schedule

Only 4 doses a year after 1st year of therapy.[6]

STELARA® Solution for Injection 45mg/0.5ml. ABBREVIATED PRESCRIBING INFORMATION[7]
ACTIVE INGREDIENT(S): Ustekinumab. **INDICATION(S):** : Plaque Psoriasis – Treatment of chronic moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy in adult patients. Psoriatic Arthritis – STELARA, can be used alone or in combination with methotrexate (MTX), for the treatment of active psoriatic arthritis in adult patients.**DOSAGE & ADMINISTRATION:** For subcutaneous injection. Recommended dose of 45 mg at Weeks 0 and 4, then every 12 weeks thereafter. Alternatively, 90 mg may be used in patients with a body weight greater than 100 kg. **CONTRAINDICATIONS:** Known severe hypersensitivity to STELARA or any of its components. Severe infections such as sepsis, tuberculosis and opportunistic infections. **SPECIAL WARNINGS & PRECAUTIONS:** Carcinogenesis and Mutagenesis: Malignancies have been reported in patients receiving ustekinumab. Caution should be exercised in patients with a history of malignancy or when considering continuing treatment in patients who develop a malignancy. Hypersensitivity Reactions: Serious allergic reactions, including anaphylaxis and angioedema, have been reported. Stop STELARA if these are developed. Immunization: Live viral or bacterial vaccines not to be given concurrently with STELARA. Immunosuppression: Caution should be exercised when considering concomitant use of immunosuppressive agents and STELARA. Immunotherapy: Caution should be exercised in patients receiving or who have received allergy immunotherapy particularly for anaphylaxis. Infections: Serious bacterial, fungal, and viral infections have been reported. STELARA should not be given to patients with an existing clinically important, active infection. Caution should be exercised when in patients with a chronic infection or a history of recurrent infection. Evaluate patients for tuberculosis prior to initiating treatment with STELARA. Initiate treatment of latent tuberculosis prior to administering STELARA. If a serious infection develops, stop STELARA should not be administered until the infection resolves. Neurologic: One case of Reversible Posterior Leukoencephalopathy Syndrome (RPLS) was reported. If RPLS is suspected, treat promptly and discontinue STELARA. **SIDE EFFECTS:** Nasopharyngitis, headache and upper respiratory tract infection. Refer to full prescribing information for other side effects. **PREGNANCY & LACTATION:** STELARA should be given to a pregnant woman only if the benefit clearly outweighs the risk. For nursing women, a decision should be made whether to discontinue nursing or to discontinue drug. **INTERACTIONS:** Live vaccines, immunosuppressants. **PLEASE REFER TO FULL PRESCRIBING INFORMATION BEFORE PRESCRIBING.** aPI version to be quoted on promotional material: Stelara aPI ver 3.0

References:
1. P.17 & Appendix J: Choice of biologic treatment for Psoriasis (Decision aid). British Association of Dermatologists guidelines for biology therapy for psoriasis 2017.
2. Warren R, et al. J Invest Dermatol 2015: 135, 2632-2640. 3. Gniadecki R, et al. Br J Dermatol 2015;172:244-252. 4. Menter A, et al. J Eur Acad Dermatol Venereol 2016; 30: 1148-1158. 5. Papp K, et al. J Drugs Dermatol 2015; 14: 706-714. 6. Stelara® (ustekinumab) packing insert (P04 416775) 7. Stelara aPI ver 3.0

Janssen
PHARMACEUTICAL COMPANIES of Johnson & Johnson

Unit 1302-1307, Tower 1, Grand Century Place,
193 Prince Edward Road West, Mongkok, Kowloon, Hong Kong
Tel : 2736 1711 Fax : 2736 1926

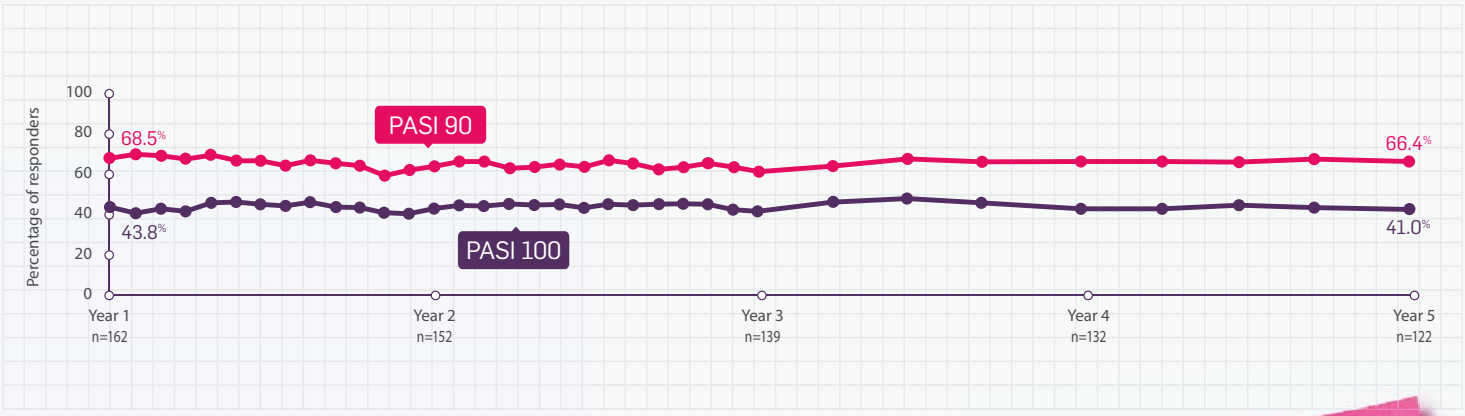
Stelara®
(ustekinumab)

CP-03880

Cosentyx®
secukinumab

"The 5 year data gives us both confidence that her clear skin will last*"

***Almost 100% of PASI response rates maintained for up to 5 years [1]**



That's Cosentyx

Long Lasting*. Complete treatment**.

Complete treatment

- 8 out of 10 patients achieve PASI 90 and almost 5 out of 10 patients achive PASI 100 at Week 16[2]
- Demonstrated efficacy in psoriatic arthritis and hard-to-treat psoriasis (scalp, nail and palmoplantar psoriasis)[3-7]

Works fast and lasts

- 50% of patients achieve PASI 75 at week 4[2]
- Almost 100% of PASI response rates maintained for up to 5 years[1]

Lasting confidence

- Used in over 160, 000 patients[8]
- No new safety signals seen in clinical studies up to 5 years[1]

* Long lasting refers to the fact that Cosentyx has shown long term 5 years efficacy in the study of Secukinumab Demonstrates High Sustained Efficacy and a Favorable Safety Profile in Patients with Moderate to Severe Psoriasis through 5 Years of Treatment (SCULPTURE Extension Study)[1].

** Complete treatment refers to the fact that Cosentyx is approved to treat various manifestations of psoriasis (psoriatic arthritis, scalp, nail and palmoplantar)[3-7].

Cosentyx®

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

References: 1. Bissonnette R et al. JEADV 2018; doi: 10.1111/jdv.14878. [Epub ahead of print]. 2. Thaçi D et al. J Am Acad Dermatol 2015; 73(3): 400-409. 3. Reich K et al. Poster FRI0460 presented at EULAR 2016. 4. Cosentyx Summary of Product Characteristics. August 2017. 5. Bagel J et al. Abstract presented at EADV 2016. 6. Kavanaugh A et al. Arthritis Care Res 2017; 69: 347-355. 7. Gottlieb A et al. Poster presented at WCD 2017. 8. Novartis data on file (160,000 patients).

HK1810901029

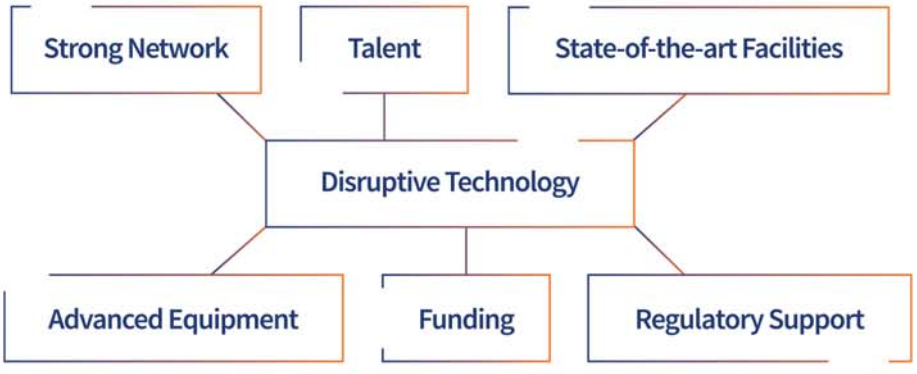
NOVARTIS

Novartis Pharmaceuticals (HK) Ltd
27/F, 1063 King's Road, Quarry Bay, Hong Kong
Tel: 2882 5222 Fax: 2573 8804

Hong Kong Science Park -

An Ideal Place for Biomedical Technology

Winning Formula for BIOMEDICAL COMPANIES



Browse this website to know more about Biomedical Technology Cluster

Contact us on **enquiry.marketing@hkstp.org** for further information!

T : +852 2629 1818 **E : enquiry.marketing@hkstp.org**

hkstp.org

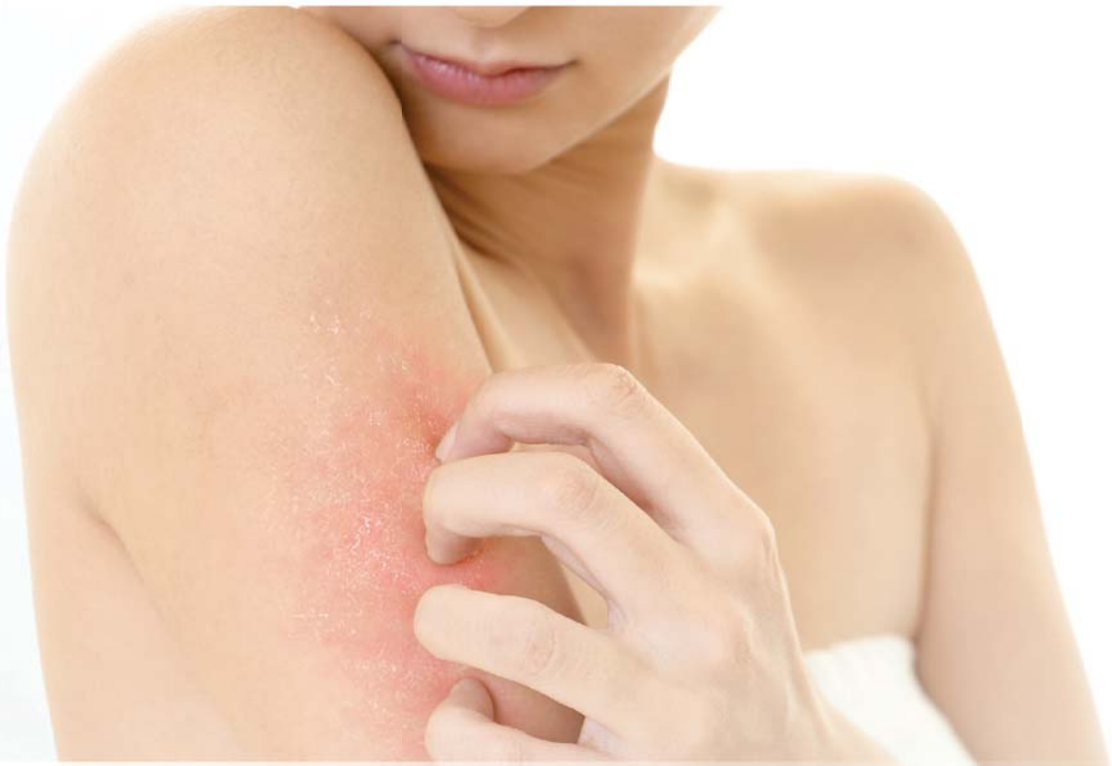
hkstp | hong kong science park | hksciencepark

Let's Shape a Brighter Future Together

HKSTP 香港科技園

Introducing
QV Intensive with Ceramides

QV Intensive with Ceramides unique dual action helps to restore epidermal barrier function



- Delivers ceramides (EOP & NP), cholesterol and free fatty acids in the optimum 3:1:1 molar ratio which has been shown to help support and replenish the epidermal barrier [1]
- Provides L-lactic acid and niacinamide, which have been shown to help support synthesis of ceramides from within [2,3]
- Increases skin hydration and reduces TEWL [4]
- Rehydrates and soothes dry, itchy or damaged skin [4]

SUITABLE FOR ECZEMA-PRONE, EXTREMELY DRY & ITCHY SKIN

ego the science of healthy skin™

www.egopharm.com
Tel: 852 3706 8380

References:
1. Rawlings AV and Maibach HI. Illinois: Allured books; 2011. Chapter 44, p 367-80. **2.** Tanno O, Ota Y, Kitamura N, Katsube T and Inoue S. Brit J Dermatol. 2000; 143: 524-531.
3. Rawlings AV, Davies A, Carlomusto M et al. Arch Dermatol Res 1996; 288(7): 383-390. **4.** Data on file; Spada, F, Greive KA and Barnes TM, 2018

HK 09/2018