DPP 2018

亞洲糖尿病基金會
Asia Diabetes Foundation

Diabetes Preventing the Preventables Forum 2018

dpp2018.adf.org.hk

6 May 2018 • Hong Kong

Supporting organizations:

香港糖尿科護士協會
Association of Hong Kong Diabetes Nurses

HKDA
香港營養師協會
HONG KONG DIETITIANS ASSOCIATION

中國香港體適能總會
Physical Fitness Association of Hong Kong, China

Youth Diabetes Action
兒童糖尿協會

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WELCOME MESSAGE

Dear faculty and delegates,

Every person with diabetes has a unique set of risk factors which the care team has to systematically collect, manage and monitor in order to prevent premature death and disabilities for preserving the quality of life.

The most challenging aspect in managing diabetes is to help patients manage their disease for the rest of their life and to personalize treatment choices at different stages of the disease.

The DPP Forum is an annual meeting which aims to foster collaborations amongst relevant stakeholders to develop care models which can bring out the best of our expertise and technologies in order to make chronic care accessible, sustainable and affordable.

To this end, we have invited a faculty of experts and thought leaders with a diversity of experiences who will share with us their views and insights into this health care challenge.

We hope you will enjoy this meeting and that you will continue to be part of this growing network in pursuit of prevention and control of diabetes and chronic disease.

Best regards,

Professor Juliana Chan
Chairman and Programme Committee

ORGANIZER

亞洲糖尿病基金會
Asia Diabetes Foundation

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SUPPORTING ORGANIZATIONS

香港糖尿科護士協會
Association of Hong Kong Diabetes Nurses

HKDA
香港營養師協會
HONG KONG DIETITIANS ASSOCIATION

中國香港體適能總會
Physical Fitness Association of Hong Kong, China

Youth Diabetes Action
兒童糖尿協會

ORGANIZING COMMITTEE

Chairman: Prof. Juliana Chan

Members: Ms. Amy Fu
Ms. Vanessa Lau
Prof. Andrea Luk
Mr. Clement Siu

PROGRAMME COMMITTEE

Members: Prof. Alice Kong
Dr. Alvin Cheung
Prof. Andrea Luk
Dr. Elaine Cheung
Dr. Elaine Chow
Prof. Juliana Chan
Prof. Ronald Ma
Dr. Risa Ozaki
Dr. Rose Ting
Ms. Rebecca Wong

FACULTY MEMBERS

Tan Mui Chan

Consultant Physician in Public Health and Head of Unit for NCD Prevention and Health Promotion, Health Bureau, Macau

Dr. Tan Mui Chan works in area of policy-making and implementing on health promotion, NCD prevention and control over 15 years. She is focal point for NCD and former focal point for the Tobacco Free Initiative in the Macau Health Bureau. Since 2009, Dr. Chan is responsible for the prevention and control of chronic diseases. It mainly focuses on the integration and prevention of hypertension, heart disease, diabetes, cancer and chronic obstructive pulmonary disease (COPD), and plans and executive the program. In particular, she created the Macau Comprehensive Colorectal Cancer Screening Program, Macau Healthy Diet Guidelines, Surveillance of Prevalence of Non-communicable diseases and Adolescent Health Behavior.

Dr. Chan is advocator, planner and implementer of the Macau Healthy City project, healthy promoting school, healthy lifestyle promotion, tobacco control and healthy building are the main program of Macau Healthy City project.

Dr. Chan was in charge tobacco control in 1999-2008, advocated establishing tobacco-free culture through promoting tobacco-free workplace, tobacco-free restaurant, carried out tobacco survey as well as GYTS, collected data of public views on tobacco control for the amendment of the law.

Elaine Yun-ning Cheung

Senior Medical Officer, Department of Medicine and Geriatrics, United Christian Hospital, Hong Kong

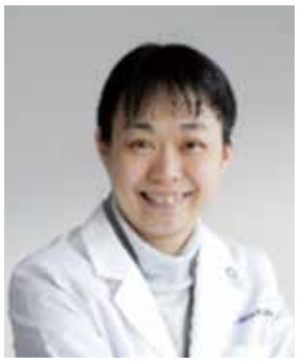
Dr. Elaine Cheung is a specialist in endocrinology and is currently the Senior Medical Officer of United Christian Hospital. She is also the Honorary Clinical Associate Professor of Hong Kong Institute of Diabetes and Obesity, the Chinese University of Hong Kong and Honorary Senior Research Associate of Asia Diabetes Foundation. Dr. Cheung graduated from the University of Hong Kong and obtained her fellowship in internal medicine in 1999 and endocrinology, diabetes and metabolism in 2004. She attained her Medical Doctorate degree in 2015 in the field of osteoporosis under the supervision of Prof. Annie Kung. She has published 12 articles in peer reviewed journals in the field of osteoporosis and related topics. Her main research focus is in diabetes epidemiology and osteoporosis.

FACULTY MEMBERS

Elaine Yee Kwan Chow

Clinical Lecturer, Phase 1 Clinical Trial Centre and Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Hong Kong

Dr. Elaine Chow is a Clinical Lecturer of the Phase 1 Clinical Trial Centre and Department of Medicine and Therapeutics at The Chinese University of Hong Kong. She was a Clinical Research Fellow of the University of Sheffield, United Kingdom and NIHR Cardiovascular Biomedical Research Unit at the Northern General Hospital, Sheffield, United Kingdom. Her main research areas are beta-cell function and insulin sensitivity in familial young onset diabetes, continuous glucose monitoring devices, and hypoglycaemia-related sudden cardiac death in diabetes. She is currently principal investigator for several studies evaluating continuous glucose monitoring devices and comparing the effect of different insulins on glycaemic variability.



Alice Pik Shan Kong

Associate Professor, Division of Endocrinology and Diabetes, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Prof. Alice Kong is the Associate Professor in the Division of Endocrinology and Diabetes at the Department of Medicine and Therapeutics, Faculty of Medicine, the Chinese University of Hong Kong, and Honorary Associate Consultant at the Prince of Wales Hospital, Hong Kong. Prof. Kong graduated from the Chinese University of Hong Kong and had her overseas training as postdoctoral fellow at the Division of Endocrinology, Department of Medicine at University of California, San Diego, United States between 1998 and 1999.

Prof. Kong is the Steering Committee Member of Joint Asia Diabetes Evaluation (JADE) Program. Prof. Kong's research interests are obesity, insulin resistance and diabetes with particular focus on lifestyle factors and care models. She is an invited reviewer for many local and international journals, including Annals of Internal Medicine, Diabetes, etc. She is an Associate Editor of Primary Care Diabetes and an editorial board member of Current Diabetes Reports. She has presented at numerous meetings and has published over 190 articles in peer-reviewed journals.

FACULTY MEMBERS

Sylvia See Way Lam

Chairman, Hong Kong Dietitians Association, Hong Kong

Ms. Sylvia Lam obtained her Master of Nutrition and Dietetics qualification from the University Sydney, Australia in 2000. She has been practicing in Hong Kong for 17 years specializing mainly on areas of diabetes, cardiac rehabilitation, weight management and other obesity related conditions and also eating disorder both in public and private setting. She is currently the Senior Dietitian in Pro-Cardio Heart Diseases and Stroke Prevention Centre in Hong Kong. She has been the Chairperson of the Hong Kong Dietitians Association since 2007, actively promoting Hong Kong's dietitian profession.

Ms. Lam often provides nutrition seminars to local and international conferences, corporate companies, school and academic institutions. She is also a reputable spokesperson for providing accurate and up-to-date nutrition education and information to the general public through newspapers, television and radio programs. Besides, she published 10 nutrition cookbooks including topics in diabetes, heart diseases, weight management, vegetarianism, cancer, infant and child nutrition and more.

Andrea On Yan Luk

Associate Professor, Division of Endocrinology and Diabetes, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Dr. Andrea Luk is a specialist in endocrinology and is currently the Associate Professor, Division of Endocrinology and Diabetes at the Department of Medicine and Therapeutics, Faculty of Medicine, the Chinese University of Hong Kong. She is also the Deputy Medical Director of the Phase 1 Clinical Trial Centre at the Chinese University of Hong Kong, Honorary Associate Consultant at the Prince of Wales Hospital, and the Deputy Medical Director of the Asia Diabetes Foundation.

Dr. Luk graduated from the University of Auckland, New Zealand, and received post-graduate training in Sydney, Australia and Hong Kong. She obtained her fellowship in endocrinology, diabetes and metabolism in 2007 at the Hong Kong College of Physicians. Her research focus is in diabetes epidemiology with special interests in diabetic kidney disease and young-onset diabetes. She is also extensively involved in clinical trials from Phase 1 through to Phase 3.

FACULTY MEMBERS

Roger Mazze

Director, AGP Clinical Academy, United Kingdom and Visiting Professor, Nanjing Medical University, China

Prof. Roger Mazze is the past head of the World Health Organization Collaborating Center (a joint program of the International Diabetes Center and Mayo Clinic), Clinical Professor, University of Minnesota Medical School (retired), and Visiting Professor, Nanjing Medical University in China. He is also the recipient of American Diabetes Association 2017 Harold Rifkin Award for Distinguished International Service in the Cause of Diabetes.

Prof. Mazze has over 80 peer reviewed publications and the author and co-author of more than 20 books on topics related to diabetes management. He is the principal author of *Staged Diabetes Management (SDM)*, a systematic evidence-based approach to diabetes care. In 2011, the government of China selected SDM as the core curriculum for the China Initiative for Diabetes Excellence (CIDE). Co-directed by Prof. Linong Ji and Prof. Roger Mazze, the program reached 500 diabetes specialists throughout China.

In research, Prof. Mazze is credited with the development of the memory-based reflectance meter and software designed to aid in clinical decision-making. He also developed the Ambulatory Glucose Profile (AGP), an innovative translational approach to clinical decision-making using continuous glucose monitoring technology. In 2014, with Dr. Iain Cranston, he started the AGP Clinical Academy in Portsmouth, United Kingdom for the purpose of advancing glucose sensing technologies and their implementation in clinical decision-making.

Masato Odawara

Director and Professor, Department of Diabetes, Endocrinology, Metabolism and Rheumatology, Tokyo Medical University, Japan

Prof. Masato Odawara is a specialist in endocrinology and is currently the Director and Professor, Department of Diabetes, Endocrinology, Metabolism and Rheumatology, Tokyo Medical University. He is also the President of Japan Society of Non-communicable Diseases. Prof. Odawara graduated from the University of Tokyo. His research focus is in genetic predisposition for the development of type 2 diabetes mellitus and diabetic microvascular and macrovascular complications. He is also extensively involved in clinical trials on diabetic complications and treatment.

FACULTY MEMBERS

Waynee H-H Sheu

Superintendent and Professor of Medicine, Taichung Veterans General Hospital, Taiwan

Prof. and Dr. Wayne Sheu is the Superintendent of Taichung Veterans General Hospital in Taichung, Taiwan and holds several Adjunct and Consulting Professor of medicine at several medical schools in Taiwan. He is Currently the President of Diabetes Association ROC (Taiwan), as well as the immediate past Chair (2016 to 2017) of the International Diabetes Federation Western Pacific Region (IDF-WPR). Prof. Sheu has authored and co-authored more than 350 original articles in the areas of diabetes, endocrinology, hypertension, obesity and coronary heart disease.

Tammy Tak Yee So

Advanced Practice Nurse, Prince of Wales Hospital, Hong Kong

Ms. Tammy So is currently the Advanced Practice Nurse and Diabetes Educator of Diabetes and Endocrine Centre, the Prince of Wales Hospital (IDF Centre of Education and IDF Centre of Care Excellence). She obtained her master degree in advanced practice in 2005 at the University of Newcastle, Australia. Besides, she acquired the fellowship in medical nursing in 2012.

Ms. So is the editorial board member of Diabetes Hong Kong newsletter and AHKDN newsletter for more than 10 years. Further, she was awarded AHKDN Outstanding Achievement Awards in 2009 & 2013. Her main interest involves exercise promotion program in community level, weight management and peer support activities.

Priscilla Ching Han Wong

Associate Consultant, Department of Medicine and Therapeutics, Prince of Wales Hospital, Hong Kong

Dr. Priscilla Wong graduated from the Chinese University of Hong Kong. She received her specialist training in rheumatology and acute internal medicine in the Prince of Wales Hospital. Currently she is the Associate Consultant of the Department of Medicine and Therapeutics at the Prince of Wales Hospital and the Honorary Clinical Assistant Professor at the Chinese University of Hong Kong. She is a council member of the Hong Kong Society of Rheumatology.

FACULTY MEMBERS

Daisuke Yabe

Program-Specific Associate Professor, Department of Diabetes, Endocrinology and Nutrition, Graduate School of Medicine, Kyoto University, Japan

Prof. Daisuke Yabe has been investigating pathophysiology of type 2 diabetes in Asian population. His research interests include secretion and action of incretins, as well as clinical safety and efficacy of incretin-based therapies in management of type 2 diabetes. He also studies molecular basis underlying proliferation and differentiation of pancreatic beta cells.

Theresa Hoi Ming Yeung

Advanced Practice Nurse, Prince of Wales Hospital, Hong Kong

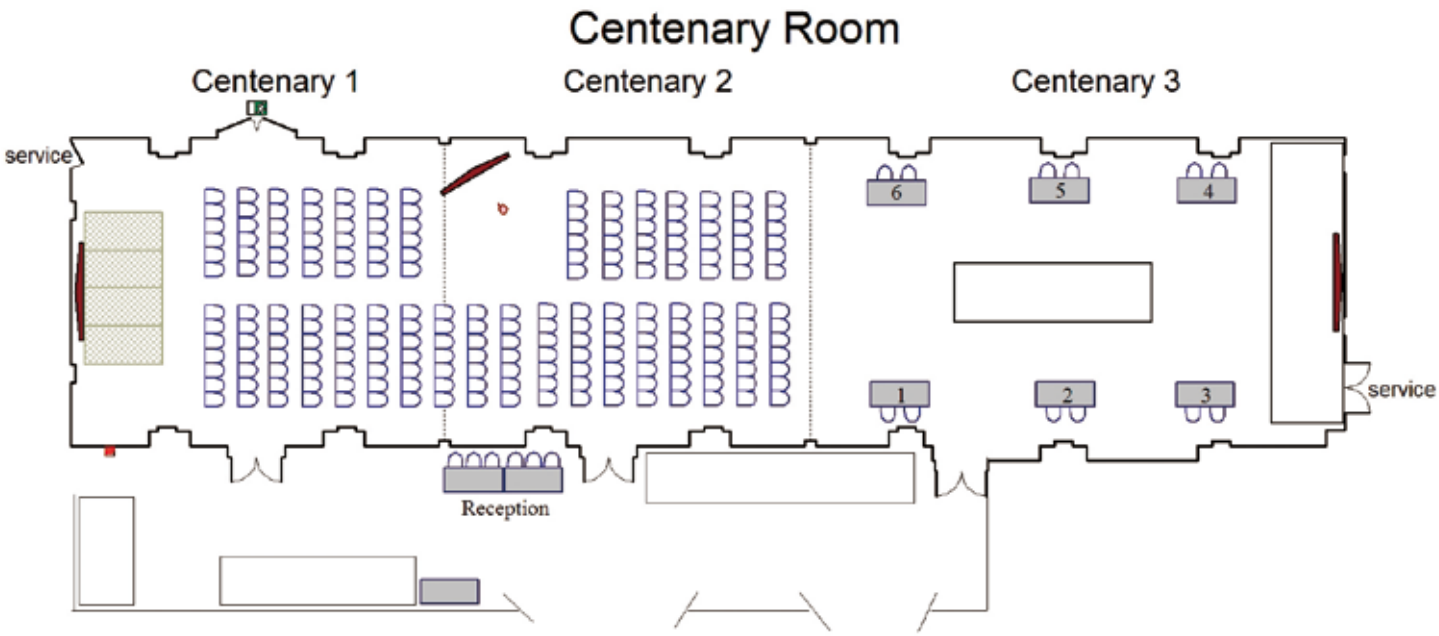
Ms. Theresa Yeung is currently the Advanced Practice Nurse of Diabetes and Endocrine Centre, the Prince of Wales Hospital (IDF Centre of Education and IDF Centre of Care Excellence). She is also the council member of the Association of Hong Kong Diabetes Nurse and Honorary Medical Advisor of Youth Diabetes Action Council. Ms. Yeung obtained her master of science in endocrinology, diabetes and metabolism in 2006 at the Chinese University of Hong Kong. Besides, she acquired the fellowship in medical nursing in 2012. One of her interests involves management of paediatric patients with diabetes.

SCIENTIFIC PROGRAMME

6 May (Sunday)		
09:25 - 09:30	Welcome remarks	
Symposium 1		**Co-chairs: KP Lau & Risa Ozaki**
09:30 - 10:00	Meal sequence, incretin response and glycaemic control	Daisuke Yabe, Japan
10:00 - 10:30	Ketogenic diet and intermittent fasting in diabetes and obesity	Sylvia Lam, Hong Kong
10:30 - 10:50	Coffee Break	
Symposium 2		**Co-chairs: Victor Hung & Alice Kong**
10:50 - 11:20	Self monitoring of blood glucose versus continuous glucose monitoring: improving diabetes care	Roger Mazze, United States of America
11:20 - 11:50	Glycaemic variability: does it matter?	Elaine Chow, Hong Kong
Lunch Symposium		**Co-chairs: Eric Hui & Alvin Cheung**
11:50 - 12:20	Scheme of diabetes prevention and delivery of diabetes care in Macau	Tan Mui Chan, Macau
12:20 - 13:20	Lunch	
Symposium 3		**Co-chairs: Bonnie Kwan & Rose Ting**
13:20 - 13:50	Can drugs be used in diabetes to prevent cancer?	Wayne H-H Sheu, Taiwan
13:50 - 14:20	Diabetes and bone health	Elaine Cheung, Hong Kong
14:20 - 14:50	Uric acid in diabetes – to treat or not to treat	Priscilla Wong, Hong Kong
14:50 - 15:10	Coffee Break	
Symposium 4		**Co-chairs: Peter Tong & Veronica Hung**
15:10 - 15:40	Updates on medical therapy of obesity	Andrea Luk, Hong Kong
15:40 - 16:10	Therapeutic advances in new basal insulin analogue and GLP-1 receptor agonist	Masato Odawara, Japan
16:10 - 17:10	From patient care to peer support - case sharing by patient, doctor and nurse	Alice Kong, Andrea Luk, Tammy So and Theresa Yeung, Hong Kong
17:10 - 17:15	Closing remarks	

FLOOR PLAN AND EXHIBITORS

Floor Plan



Exhibitors

Booth No.	Exhibitors Name
1	AstraZeneca Hong Kong Ltd.
2	Eli Lilly Asia, Inc.
3	Merck Sharp & Dohme (Asia) Ltd.
4	Novartis Pharmaceuticals (HK) Ltd.
5	Sanofi-aventis Hong Kong Ltd.
6	Woerwag Pharma GmbH & Co. KG

ACADEMIC ACCREDITATIONS (UPDATED)

Name of Institutions	CDE/CE/CEU/CME/CNE/ CPD points
Association of Hong Kong Diabetes Nurses Limited	5.5
College of Ophthalmologists of Hong Kong	3
Hong Kong College of Community Medicine	5
Hong Kong College of Emergency Medicine	6
Hong Kong College of Paediatricians	6 (Cat. A)
Hong Kong College of Physicians	6
Hong Kong College of Radiologists	6 (Cat. B)
Hong Kong Dietitians Association	1 core and 4 non-core
Hong Kong Nutrition Association Limited	6
Hong Kong Physiotherapy Association Limited	5
International Podiatrists Association of Hong Kong	10
MCHK CME Programme	5
Occupational Therapists Board	3
Pharmacy Central Continuing Education Committee	5.5
Radiographers Board	5
The College of Dental Surgeons of Hong Kong	5.5 (Cat. B)
The College of Surgeons of Hong Kong	6
The Hong Kong College of Anaesthesiologists	6 (non-anaesthetic)
The Hong Kong College of Family Physicians	5 (Cat. 5.2)
The Hong Kong College of Obstetricians and Gynaecologists	Pending
The Hong Kong College of Orthopaedic Surgeons	Pending
The Hong Kong College of Otorhinolaryngologists	3 (Cat. 2.2)
The Hong Kong College of Pathologists	6
The Hong Kong College of Psychiatrists	6

SYMPOSIUM 1

09:30 - 10:00

Meal sequence, incretin response and glycaemic control

Daisuke Yabe

Program-Specific Associate Professor, Department of Diabetes, Endocrinology and Nutrition, Graduate School of Medicine, Kyoto University, Japan

It is becoming widely recognized that Asian type 2 diabetes mellitus (T2DM) is characterized primarily by beta-cell dysfunction, which is evident immediately after meal ingestion, and by generally less obesity and higher insulin sensitivity compared to Caucasians (Lancet Diabetes Endocrinol. 2016 Jan;4(1):2-3). These pathophysiological differences can have a great impact on the appropriate anti-diabetes prevention approach. Recently, the incretins and incretin-based therapies have been gaining much attention in T2DM prevention and management in Asia. The incretins, glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1), are secreted from the gut in response to ingestion of various nutrients including carbohydrates, proteins and lipids, and enhance insulin secretion glucose-dependently to exert their glucose-lowering effects (J Diabetes Investig. 2010 Apr 22;1(1-2):8-23). It is also demonstrated that GLP-1 delays gastric emptying and suppresses glucagon secretion to prevent postprandial glucose excursion; and that GLP-1 induces satiety, thereby reducing bodyweight. In contrast, GIP, in collaboration with saturated and mono-unsaturated fats, stimulate energy storage into adipose tissues, linking to obesity. We demonstrated in a hospital setting that eating fish before rice enhanced GLP-1 secretion and ameliorated postprandial glucose excursions by increasing insulin secretion and delaying gastric emptying, in comparison with eating fish after rice (Diabetologia. 2016 Mar;59(3):453-61). Similar reversal of rice and meat, which is rich in saturated and mono-unsaturated fats that enhance not only GLP-1 secretion but also that of GIP, facilitates fat accumulation. Therefore, types of fats ingested before carbohydrate should be carefully chosen. Using continuous glucose monitoring, we have recently shown that dietary instructions including the meal-sequence are highly effective in reducing postprandial glucose elevation in healthy volunteers. Furthermore, we have also demonstrated that dietary instructions including the meal-sequence are more effective than conventional instructions in reducing bodyweight and total calorie intake among prediabetes subjects with similar adherence rates during the 6-month observational periods. Thus, the meal-sequence is important not only for the management of type 2 diabetes but for its prevention. In the current presentation, we would like to discuss potential of the meal-sequence in T2DM prevention in Asia.

10:00 - 10:30

Ketogenic diet and intermittent fasting in diabetes and obesity

Sylvia See Way Lam
Chairman, Hong Kong Dietitians Association, Hong Kong

Ketogenic diet (which also referred to "keto" diet) and intermittent fasting have recently been very popular among different weight loss methods available in the market. Keto diet refers to a diet consists of very low amount of carbohydrates (<10% of total energy intake) and high amount of fat (>70% of total energy intake). It involves drastic reduction in carbohydrate intake and replacing it with fat. The claimed objective is to put your body into a metabolic state called ketosis.

Recent studies showed that ketogenic diet might be beneficial to weight loss, especially in short term, along with certain degree of improvement in the glycaemic control including blood sugar level and insulin sensitivity of people with diabetes due to significant weight loss. Some studies even showed that it could help reduce diabetic medication after drastic changes in the diet. However, ketogenic diet might lead to some short-term side effects including headaches, dizziness, fatigue, leg cramps, constipation, bad bread while long term side effects including muscle loss, weight rebound, nutritional deficiency, reduced exercise performance and other possible side effects which weren't identified in current evidence.

Besides ketogenic diet, intermittent fasting has been gaining a lot of attention lately. Intermittent fasting is a term for an eating pattern that cycles between periods of fasting and eating. Fasting has been part of major religions including Islam, Christianity, Judaism and Buddhism. Modern day intermittent fasting can involve fasting from a few hours per day to 1-2 days per week without eating or eating very few calories (e.g. <600kcal) on fasting days. Studies on intermittent fasting showed such eating pattern might improve human grown hormone, insulin sensitivity, cellular repair, reduction in inflammatory markers, even on gene expression which leads to longetivity and reduced risk of chronic disease including diabetes. Due to a reduction of calorie intake by 25% to 30% in average per day, intermittent fasting was shown to help weight loss without compromising metabolic rate and muscle loss comparing to extremely calorie restriction.

Improper dieting can lead to poor nutritional status even with the results of weight loss and improvement in glycaemic control. Nevertheless, sustainability to these extreme diets remains questionable.

One diet might not work for all. Therefore, when choosing trendy diets as mentioned above, one has to balance between the long-term benefits and harms before starting a new diet programme.

SYMPOSIUM 2

10:50 - 11:20

Self monitoring of blood glucose versus continuous glucose monitoring: improving diabetes care

Roger Mazze
Director, AGP Clinical Academy, United Kingdom and Visiting Professor, Nanjing Medical University, China

Since its introduction, self-monitored blood glucose (SMBG) promised an important place in diabetes management. Specifically, the collection and presentation of *verified, unbiased, accurate* and *reliable* glucose data that would provide the basis for clinical decision-making. Over the past four decades, SMBG use in clinical practice, patient education and research has been aimed at characterizing glucose control and improving diabetes management by providing immediate feedback to the patient to enable alterations in medication, diet and activity. Patients have been given various tools to optimize SMBG data including elaborate algorithms that "calculate" insulin dose. Clinicians routinely use SMBG data to select and adjust treatment and assess overall glycaemic control. Multi-center trials employ SMBG to assist patients in achieving research goals. However, due to patient error, false reporting, testing bias and other factors, SMBG has not met its promise. Consequently, whether in patient care or research SMBG has unequivocally proven to meet its stated purpose.

In 2008 the first portable continuous glucose monitoring (CGM) system was introduced and over the next decade underwent significant technological improvements that enable continuous monitoring for as much as 14 days without the need of self-calibration. CGM provides accurate, reliable, unbiased and verifiable data in a format that optimizes evidence-based clinical decision-making. Using the ambulatory glucose profile (AGP) as a means of graphically representing glucose values, glucose exposure, variability, stability, and hypoglycaemia risk can be assessed. In clinical care, CGM is used to add specificity to diagnoses, aid in therapy initiation and adjustment, and assess clinical outcomes. In education, CGM allows the patient immediate feedback with trend analysis, essentially enabling the patient to "predict" whether glucose is rising or falling and to take steps to prevent detrimental glucose excursions. In research, CGM enables discovery of the pharmacodynamics of medications, mapping prandial and post prandial periods, and assessing glycaemic control throughout various levels of physical exertion.

In sum, the promise that once was SMBG may eventually be fulfilled by CGM.

11:20 - 11:50

Glycaemic variability: does it matter?

Elaine Yee Kwan Chow

Clinical Lecturer, Phase 1 Clinical Trial Centre and Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Hong Kong

There has been a recent movement to go beyond HbA_{1c} as the only measure of glycaemic control as it does not reflect the daily fluctuations in glucose. With the emergence of continuous glucose monitoring (CGM) technology, physicians and patients now have access to a wealth of detailed blood glucose data. In a normal person, blood glucose is tightly regulated within a narrow range. However, diabetes patients, especially type 1 diabetes patients, have frequent glucose excursions rising rapidly post meal or declining rapidly following insulin. This degree of glucose fluctuation, or glycaemic variability (GV), may be quantified using CGM-based measures such as coefficient of variation or standard deviation.

We know that high GV is a predictor for severe hypoglycaemia. The contribution of GV towards complication risk, above and beyond that of the level of glycaemia is a subject of debate. GV has been associated with oxidative stress, however, there is a still no definite evidence that GV is linked to long-term microvascular and macrovascular complications.

In this talk, I shall discuss whether GV should be a target for clinical management. I shall also discuss choice of glucose-lowering therapies, such as newer insulins and GLP-1 receptor antagonists, that may be associated with lower GV.

LUNCH SYMPOSIUM

11:50 - 12:20

Scheme of diabetes prevention and delivery of diabetes care in Macau

Tan Mui Chan

Consultant Physician in Public Health and Head of Unit for NCD Prevention and Health Promotion, Health Bureau, Macau

Similarly to the other developed countries and area, diabetes mellitus is one of main endemic chronic disease in Macau SAR. As type 2 diabetes is preventable with simple lifestyle measure, a large proportion of diabetes cases are effective controlled and delaying the onset of side effect with the early diabetes care, the diabetes is prevented and controlled in three health care levels in Macau:

First level, Macau SAR government set up the Committee on Non-Communicable Disease Prevention and Control in 2009, one of tasks of committee is to integrated the diabetes prevention and control program, empowerment, structure diabetes education, promoting maintaining normal body weight, engaging in regular physical activity and eating a healthy diet, promote effective self-management of diabetes.

Second level, diabetes care was delivery in all health centers, including routine follow up for the blood glucose control and preventing complications, nursing consultation for DM patient foot examination, retina screening, multidisciplinary team approach in poorly controlled cases and a series of health education for DM patients and their family.

Third level, poorly controlled diabetes cases are referred to specialist services, as well as further study the cardiovascular diseases caused by diabetes, diabetes foot, renal failure, retinopathy and follow up with adequate expert management. The patients will be referred back to health centers when their conditions are stable.

The above three levels is a primary and specialist service in Macau, which were integrated upon the need and ability of the patient to manage their condition.

Recently, Macau government emphasis the importance of self-management of the patient, provide support to the patient to take personal responsibility, by training group leader of Chronic Disease Self-management in government hospital, health centers, private medical group and NGOs, through the effort of medical professional and patients, to reduce the complications of diabetes and maintain the patient in good quality of life.

SYMPOSIUM 3

13:20 - 13:50

Can drugs be used in diabetes to prevent cancer?

Wayne H-H Sheu, Taiwan
Superintendent and Professor of Medicine, Taichung Veterans General Hospital, Taiwan

People with diabetes have higher chances to development several types of cancer. Concerns were raised for long term use of anti-diabetic drugs on onset of new cancers and prognosis of cancer management in patients with type 2 diabetes mellitus (T2DM). Metformin is a standard clinical drug used to treat T2DM and polycystic ovary syndrome. Recently, epidemiological studies and meta-analyses have revealed that patients with T2DM when treated with metformin have a lower incidence of tumor development and have a lower risk of mortality, demonstrating an association between metformin and tumorigenesis. *In vivo* and *in vitro* studies have revealed that metformin has a direct antitumor effect, which may depress tumor proliferation and induce the apoptosis, autophagy and cell cycle arrest of tumor cells. The mechanisms underpinning the antitumor effect of metformin are under extensive studies, partly in areas of reducing insulin and insulin-like growth factor levels in the peripheral blood circulation and mTOR signaling, processes that may be associated with the antitumor effect of metformin. Recent studies also suggest that some of DPP 4 inhibitor might be beneficial in preventing certain type of cancers. One recent systemic review indicated that, compared with other antidiabetic drugs, once-weekly GLP-1RAs did not increase the risk for any tumour, independent of the type of GLP-1RA administered and treatment duration. Results from our study reported that use of acarbose might reduce the risk of incident colorectal cancer in patients with diabetes in a dose-dependent manner.

13:50 - 14:20

Diabetes and bone health

Elaine Yun-ning Cheung
Senior Medical Officer, Department of Medicine and Geriatrics, United Christian Hospital, Hong Kong

Confirmed increased fracture risk among type 2 diabetes subjects

Systematic reviews have confirmed the higher fracture incidence among diabetic subjects compared to general population. In the first international symposium on diabetes and bone, experts emphasized that bone fragility (diabetes osteodystrophy) should be viewed as a chronic complication of diabetes and called for awareness in both health care professionals and patients.

Potential heightened fracture risk among Chinese type 2 diabetes subjects compared to Caucasians

While bone mineral density is often reduced in type 1 diabetic mellitus (T1DM) subjects, many subjects with type 2 diabetes mellitus (T2DM) still have preserved or high bone mineral density due to obesity. However, their bone quality as measured by trabecular bone score (TBS) or other means is often low. The lower prevalence of obesity in mellitus T2DM subjects in Asian societies compared to Caucasians may translate into an even higher fracture risk. Local study showed that among subjects with fragility fractures, those with diabetes had significantly higher BMD but lower daily calcium intake compared to non-diabetic subjects. The later fact might reflect the lower awareness and alertness to the risk of fracture in diabetic subjects compared to general population.

Worse outcome in diabetic subjects with hip fractures

Complication rate in diabetic subjects with hip fractures is higher compared to general population. Individuals with diabetes have more delayed healing, wound infection, post-operative cardiac events, increase length of study and higher mortality.

Fracture risk assessment and fracture prevention in diabetic subjects

Apart from traditional risk factors for fracture prediction, additional risk factors specific to mellitus T2DM (such as poor glycaemic control, DM duration, presence of complications, certain drug usage etc) have been identified. On the other hand, recent data suggested that the WHO fracture risk assessment tool (FRAX) may underestimate fracture risk in patients with diabetes. While diabetes does not significantly modify the effect of FRAX for major osteoporotic fracture prediction, it does exert a much stronger effect on hip fracture risk in younger individuals. It was calculated that the effect of diabetes on FRAX estimated fracture risk is equivalent to adding 10 years of age. The effects of osteoporosis drugs on reducing bone fragility in diabetic subjects remain to be prospectively evaluated.

Conclusion

Bone health in Chinese diabetic subjects is a subject of great importance. More attention is required to prevent fracture and its devastating outcome in the growing population of diabetic subjects in our society.

14:20 - 14:50

Uric acid in diabetes – to treat or not to treat

Priscilla Ching Han Wong
Associate Consultant, Department of Medicine and Therapeutics, Prince of Wales Hospital, Hong Kong

Hyperuricemia is commonly seen in our clinical practice. Hyperuricemia itself is not a disease, but it may cause gouty arthritis, and sustained hyperuricaemia is substantially implicated with cardiovascular and metabolic diseases such as ischaemic heart disease, hypertension, atrial fibrillation and metabolic syndrome. Many studies have reported that hyperuricaemia is associated with higher incidence of type 2 diabetes mellitus. A few meta-analysis studies have reported that for every 1mg/dL increase in uric acid concentration, the risks of type 2 diabetes mellitus was increased by 6-11%. The underlying reasons for these observations are unclear at present. A possible mechanism is that hyperuricaemia might be substantially implicated in insulin resistance and pancreatic beta-cell function. An increased level of uric acid concentration is negatively associated with an insulin sensitivity and positively associated with insulin resistance. It is also reported that a higher uric acid concentration was associated with worsening insulin sensitivity in patients with type 1 DM.

We all know that patients with a diagnosis of gout should be treated with urate lowering agent since gout is a painful and debilitating disease with a negative impact on morbidity and premature mortality. Now the clinical question is: for patients with diabetes mellitus who already bear a significant increase risk of cardiovascular and metabolic diseases, should we treat their hyperuricemia with urate lowering agent if they have no clinical manifestation of gout? Does lowering of serum uric acid level alter any of the features of the metabolic syndrome? Another clinical challenge is: in patients with persistent hyperuricemia but without symptoms of gouty attack, will there be subclinical gouty arthritis and other subclinical organ damage which warrants early investigation and treatment?

Identifying risk factors for the development of diabetes is essential for its early screening and prevention. This lecture will highlight whether serum uric acid is associated with higher incidence of type 2 diabetes mellitus, and the long-term impact of hyperuricaemia on type 2 diabetes mellitus and cardiovascular events. The most updated evidence-based recommendations for the management of gout will also be discussed.

SYMPOSIUM 4

15:10 - 15:40

Updates on medical therapy of obesity

Andrea On Yan Luk

Associate Professor, Division of Endocrinology and Diabetes, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

The prevalence of over-weight and obesity is rising globally and across all ages and ethnic groups. A number of factors contribute to this disturbing trend including sedentary lifestyle, unhealthy diet, stress, sleep deprivation and mood disorders. Obesity has many adverse health consequences such as type 2 diabetes, cardiovascular disease, chronic kidney disease and cancer. A 5-10% loss of body weight improves cardio-metabolic risk factors whereas aggressive weight reduction of 20-30% also lowers the incidence of cardiovascular events and mortality, although the latter is usually only achievable through bariatric surgery. Whilst lifestyle intervention remains the mainstay of obesity management, several pharmacological agents have recently emerged and have the potential to be effective adjuncts. These include glucagon-like peptide-1 receptor agonist (liraglutide), topiramate/phentermine and bupropion/naltrexone. In this presentation, I will discuss the current evidence on the use of these newer agents and address the challenges faced in managing this population.

15:40 - 16:10

Therapeutic advances in new basal insulin analogue and GLP-1 receptor agonist

Masato Odawara

Director and Professor, Department of Diabetes, Endocrinology, Metabolism and Rheumatology, Tokyo Medical University, Japan

Diabetes epidemic is a global problem. American Diabetes Association (ADA) recommends injectable therapy to treat symptomatic type 2 diabetes mellitus (T2DM) with high HbA_{1c}. There are, however, barriers for the initiation of injection among Asian populations. We did a national survey to know possible psychological barriers to the initiation of insulin injections not only in patients but also in their doctors. The survey results indicated that there are barriers on both sides. Although patients were reluctant to initiate insulin injections, they tend to accept injections fairly well after the actual initiation of insulin. And the negative images of insulin injection improved greatly after insulin initiation.

With better basal insulin analogue, glycaemic control of the patients seems to have improved. However, we still have some problems of hypoglycaemia and weight gain, which make it difficult to achieve glycaemic target. We analyzed data from ALOHA and ALOHA2 studies, observational studies using insulin glargine, and came to know that proper titration of basal insulin is necessary to achieve glycaemic target. We also came to know patient-led titrations also contributed to better glycaemic control as doctor-led titrations. QOL of the patients in patient-led titration arm was fairly good as well.

We carried out studies to know whether new generation basal insulin analogues work better in Japanese type 2 diabetic patients.

Injections of GLP-1 receptor agonists are also recommended to patients with ASCVD by ADA. CVOT results with some GLP-1 receptor agonists seem to be fairly well. I will comment on currently available data of GLP-1 receptor agonist therapy. I would also like to talk about combination treatment of GLP-1 receptor agonist and basal insulin, which seems to be quite promising to achieve glycaemic target without causing much weight gain.

16:10-17:10

From patient care to peer support - case sharing by patient, doctor and nurse

Alice Pik Shan Kong
Associate Professor, Division of Endocrinology and Diabetes, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Andrea On Yan Luk
Associate Professor, Division of Endocrinology and Diabetes, Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Tammy Tak Yee So
Advanced Practice Nurse, Prince of Wales Hospital, Hong Kong

Theresa Hoi Ming Yeung
Advanced Practice Nurse, Prince of Wales Hospital, Hong Kong

Diabetes is a complex disease which requires a biomedical-cognitive-psychological-behavioral approach to promote self management and personalize drug treatment. Throughout the life journey of a person with diabetes, he/she will have to manage his/her lifestyle and medications in order to control her condition with periodic encounters with her care team. Along the way, he/she may face other challenges or life events which may affect the control of her blood glucose and risk factors. Depending on the nature of the disease, his/her treatment may also change which demands considerable discipline in terms of adherence and adaptation.

During this panel discussion, doctors, nurses and patients will share their experiences on how they use multiple measures including the use of peer support in order to optimize care and improve quality of life of these patients affected by a life long condition.

NOTES

NOTES

DPP 2019

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ACKNOWLEDGEMENTS

The Organizing Committee would like to extend their sincere thanks to the following companies for their support to the Diabetes Preventing the Preventables Forum 2018.

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WÖRWAG PHARMA

T2DM = type 2 diabetes mellitus

References: 1. Wysham C et al. Diabetes Care 2014;37:2159-67. 2. Umpierrez G et al. Diabetes Care 2014;37:2168-76. 3. Nauck M et al. Diabetes Care 2014;37:2149-58. 4. Giorgino F et al. Diabetes Care 2015;38:2241-9. 5. Dungan KM et al. Lancet 2014;384:1349-57. 6. Blonde L et al. Lancet 2015;385:2057-66. 7. Trulicity® Instructions for Use. 8. Maehr G et al. J Diabetes Sci Technol 2015;9:1071-9. 9. Trulicity® 0.75mg and 1.5mg Prescribing Information.

Trulicity® Abbreviated Prescribing Information
Indication: Type 2 DM to improve glycaemic control as monotherapy when diet & exercise alone is inadequate in patient for whom metformin is considered inappropriate or as add-on therapy in combination w/ other glucose-lowering medicinal products including insulin, when these, together w/ diet & exercise, do not provide adequate glycaemic control. **Dosage:** Adult Monotherapy 0.75 mg once wkly. Add-on therapy 1.5 mg once wkly. Elderly ≥75 yr initially 0.75 mg once wkly. **Administration:** Injected subcutaneously in the abdomen, thigh or upper arm. It should not be administered intravenously or intramuscularly. The dose can be administered at any time of day, with or without meal. **Contraindication:** Hypersensitivity. **Special Precautions:** Do not use in patients w/ type 1 DM or for the treatment of diabetic ketoacidosis. Discontinue if pancreatitis is suspected. Hypoglycaemia. **Adverse Reactions:** Hypoglycaemia, nausea, diarrhoea, vomiting, abdominal pain, decreased appetite, dyspepsia, constipation, flatulence, abdominal distention, GERD, anorexia, Fatigue, Sinus tachycardia, 1st degree AV block.

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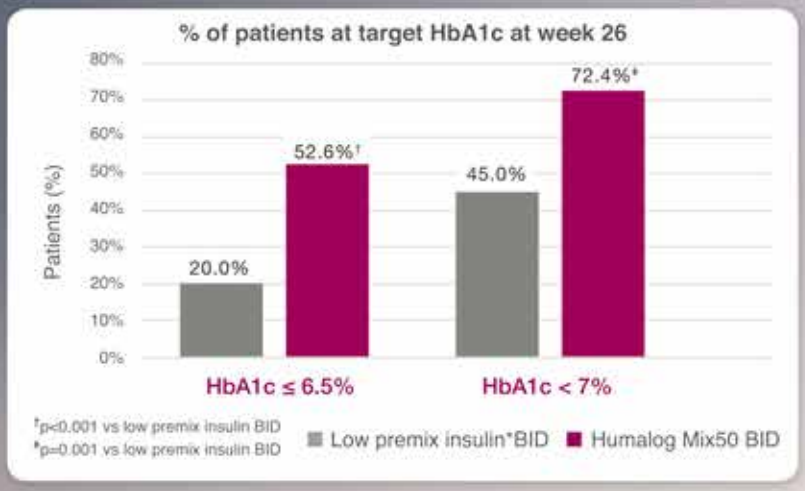
Humalog mix 50

CLASSIFY Suggests that Humalog Mix50 BID is the Better Premixed Insulin for Chinese Patients[1]

Significantly more patients achieved HbA1c target



Significantly greater HbA1c reductions from baseline

- -1.99% vs -1.58%, p<0.001

Superior results achieved through similar insulin doses

This is a subgroup analysis of the phase 4, randomized, open-label, 26-week, parallel-arm, multinational, controlled study in Chinese T2DM patients enrolled at 10 sites in China, comparing the efficacy and safety of Humalog Mix25 and Humalog Mix50 BID. Patients who met the eligibility criteria were randomized in a 1:1 ratio to Humalog Mix25 or Humalog Mix50 therapy. The primary efficacy outcome measure was the comparison of the effect of Humalog Mix25 and Humalog Mix50 on the change in HbA1c from baseline to 26 weeks. Secondary efficacy measures included a comparison of the effect of Humalog Mix25 and Humalog Mix50 on: the change in HbA1c profile over 26 weeks from baseline, percentage of patients achieving HbA1c of <7% or ≤6.5%, change from baseline in fasting plasma glucose (FPG); 7-point self-monitoring of blood glucose (SMBG) profile (before and 2 hours after meals, plus bedtime), change from baseline in 1,5 anhydroglucitol concentration, and insulin dose. Safety outcome measures included the incidence of total, severe, and nocturnal hypoglycaemic episodes, adverse events leading to discontinuation, and change from baseline in body weight.

HKCHUM2016-10-18TC1 04_51

* Low premix insulin=Humalog Mix25

BID=bi-daily. T2DM=type 2 diabetes mellitus.

Reference:
1.Su Q, Liu C, Zheng H, et al. Comparison of Insulin Lispro Mix 25 with Insulin Lispro Mix 50 as Insulin Starter in Chinese Patients with Type 2 Diabetes Mellitus (CLASSIFY Study): A Subgroup Analysis of a Phase 4, Open-Label, Randomized Trial. Journal of Diabetes 2016 Doi:10.1111/1753-0407.12442.

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In the treatment of patients with type 2 diabetes and established CV disease receiving standard of care,†‡§ **CV death can strike at any time**

BATTLE CV DEATH NOW MORE THAN EVER§

JARDIANCE demonstrated 38% RRR in CV death[1,2]

Established HbA1c efficacy[2]

Demonstrated safety profile[1,2]

Convenient, once-daily oral dosing[2]

American Diabetes Association recommends empagliflozin to reduce CV death (Level of evidence: A)[3,4#*]

Jardiance® (empagliflozin)

CV=cardiovascular; RRR=relative risk reduction; CVD=cardiovascular disease.

Reference: 1. Zinman B, et al. N Engl J Med. 2015;373(22):2117-2128. 2. Jardiance Hong Kong Prescribing Information. 3. American Diabetes Association Standards of Medical Care in Diabetes. Approaches to glycemic treatment. Diabetes Care 2018;41(Suppl.1):S73-S85. 4. American Diabetes Association Standards of Medical Care in Diabetes. Introduction. Diabetes Care 2018;41(Suppl. 1):S1-S2.

† JARDIANCE demonstrated RRR in CV death in adult patients with insufficiently controlled type 2 diabetes (baseline HbA1c 7-10%) and established CV disease (coronary artery disease, peripheral artery disease, or a history of myocardial infarction or stroke).
‡ Standard of care included CV medications and glucose-lowering agents given at the discretion of physicians.
§ Empagliflozin versus placebo on top of standard of care.
# In patients with type 2 diabetes and established atherosclerotic CVD.
* Level of evidence : A - Clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered.
^ On top of standard of care.

JARDIANCE®

Presentation: Empagliflozin. Film-coated tablet 10 mg and 25 mg. **Indications:** Adjunct to diet and exercise to improve glycaemic control in adults with type 2 diabetes mellitus as monotherapy or as combination therapy with other glucose-lowering medicinal products including insulin. **Dosage and administration:** Recommended starting dose is 10 mg once daily. For patients who tolerate 10 mg and need additional glycaemic control, their dose can be increased to 25 mg once daily. Can be taken with or without food. **Contraindication:** Hypersensitivity to empagliflozin or to any of the excipients. **Special warnings and precautions:** Should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. Should be discontinued immediately in patients where diabetic ketoacidosis is suspected or diagnosed. In patients tolerating empagliflozin whose eGFR falls persistently below 60 ml/min/1.73 m² or CrCl <60 ml/min, the dose of empagliflozin should be adjusted to or maintained at 10 mg once daily. Should be discontinued when eGFR is persistently below 45 ml/min/1.73 m² or CrCl persistently below 45 ml/min. Should not be initiated in patients with eGFR below 60 ml/min/1.73 m² or CrCl <60 ml/min; ESRD or patients on dialysis; children and adolescents; aged 85 years and older; severe hepatic impairment. Elevated haematocrit was observed in the treatment. Caution should be exercised in patients at risk for volume depletion. Temporary interruption of treatment until the fluid loss is corrected or in patients with complicated urinary tract infections. Counsel patients on routine preventative footcare as lower limb amputations has been observed with another SGLT2 inhibitor. Caution in patients with NYHA III and IV cardiac failure. Avoid use in patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption. A lower dose of the sulphonylurea or insulin may be considered to reduce the risk of hypoglycaemia when used in combination with empagliflozin. Test positive for glucose in urine. Avoid use during pregnancy; breast-feeding. Caution when driving or operating machines. **Interactions:** Diuretics, insulin & insulin secretagogues. May decrease efficacy with inducers of UGT enzymes. **Adverse reactions: Very common:** hypoglycaemia when used with sulphonylurea or insulin. **Common:** vaginal moniliasis, vulvovaginitis, balanitis and other genital infection, urinary tract infection, thirst, pruritus (generalised), increased urination, serum lipids increased. **Uncommon:** volume depletion, dysuria, blood creatinine increased, glomerular filtration rate decreased, haematocrit increased. **Rare:** diabetic ketoacidosis. **Note:** Before prescribing, please consult full prescribing information.

EXTENDED LABEL

for the treatment of patients with insufficiently controlled type 2 diabetes with established CVD.^ JARDIANCE has shown effect on glycaemic control and CV events.[2†]

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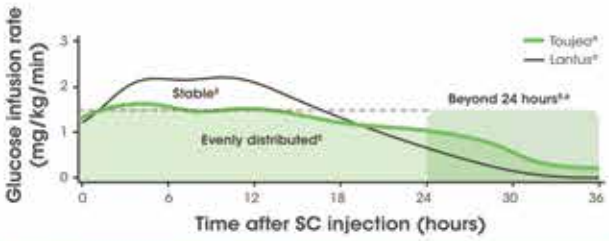

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Presentation : Insulin glargine 300 IU/ml solution for injection. **Indications** Treatment of diabetes mellitus in adults. **Dosage** Once daily (preferably at the same time every day up to 3 hours before or after the usual time of administration), with adjusted individual dosage. Please refer to the full prescribing information for guidelines on switching between other insulin preparations. **Administration** Subcutaneous injection. Toujeo is NOT INTENDED FOR INTRAVENOUS USE since it could result in severe hypoglycaemia. Toujeo must not be drawn from the cartridge of the SoloStar pre-filled pen into a syringe or severe overdose can result. Contraindications Hypersensitivity to insulin glargine or to any of the excipients. **Precautions** Toujeo has not been studied in children and adolescents below 18 years of age. Elderly:progressive deterioration of renal function may lead to a steady decrease in insulin requirements. Renal impairment: insulin requirements may be diminished due to reduced insulin metabolism. Hepatic impairment: insulin requirement may be diminished due to reduced capacity for gluconeogeness and reduced insulin metabolism. Hypoglycaemia. Intercurrent illness. Combination of Toujeo with pioglitazone. **Interactions** Effects enhanced by oral antidiabetics, ACEI, disopyramide, fibrates, fluoxetine, MAOIs, pentoxifylline, propoxyphene, salicylates, sulfonamide antibiotics. Effects reduced by corticosteroids, danazol, diazoxide, diuretics, glucagons, isoniazid, oestrogens and progestogens, phenothiazine derivatives, somatropin, sympathomimmetics, or thyroid hormones, atypical antipsychotics and protease inhibitors. Beta-blockers, clonidine, lithium or alcohol may either potentiate or weaken the effects of insulin. Pentamidine may cause hypoglycaemia, followed by hyperglycaemia. The signs of adrenergic counter-regulation may be reduced or absent under the influence of sympathalytic medicinal products such as Beta-blockers, clonidine, guanethidine and reserpine. **Fertility, pregnancy and lactation** Animal studies do not indicate direct harmful effects with respect to fertility and reproductive toxicity. The use of Toujeo may be considered during pregnancy if clinical needed. It is unknown whether insulin glargine is excreted in human milk. **Overdose** Insulin overdose may lead to severe and sometimes long-term and life threatening hypoglycaemia. Mild episodes of hypoglycaemia can usually be treated with oral carbohydrates. More severe episodes with coma, seizure or neurologic impairment may be treated with glucagon (intramuscular or subcutaneous) or concentrated glucose solution (intravenous). **Undesirable effects** Hypoglycaemia, lipohypertrophy, injection site reactions. For common, uncommon, rare and very rare undesirable effects, please refer to the full prescribing information. **Preparation** Toujeo 5 x 1.5ml (450U)pre-filled pens. **Full prescribing information is available upon request.**

* Treatment of diabetes mellitus in adults.

† This study (Becker RH, et al.Diabetes Care 2014) was a randomized, double-blind, two-treatment, two-period, two-sequence, cross-over study evaluating the PK and PD profiles of Toujeo® compared with Lantus® at steady state in people with type 1 diabetes (n=30). Cohort 1: 18 participants received Toujeo® 0.4 U/kg/day for 8 days followed by Lantus® 0.4 U/kg/day for 8 days or vice versa. Cohort 2: 12 participants received Toujeo® 0.6 U/kg/day for 8 days followed by Lantus 0.4 U/kg/day for 8 days or vice versa. The euglycemic clamp technique was applied over 36 hours. CV: cardiovascular; SC: subcutaneous; T1DM: type 1 diabetes mellitus; T2DM: type 2 diabetes mellitus.

Reference: 1. Yki-Jarvinen H et al. Diabetes, Obesity & Metabolism 2015; 17: 1142-1149. **2.** MC Riddle et al. Diabetes, Obesity & Metabolism 2015; 17: 835-842. **3.** Bergenstal R, et al. (Poster #949) presented at EASD, Vienna, September 15-19 2014. Available from: http://www.easdvirtualmeeting.org/resources/18574. Date accessed: April 2015. **4.** Ritzel et al. Diabetes, Obesity & Metabolism 2015; 17: 859-867. **5.** Becker RH. et al. Diabetes Care 2015;38(4):637-643. **6.** Toujeo Summary of Product Characteristics. February 2015. **7.** Gerstein HC. et al. New Eng J Med 2012;367:319-328. **8.** Matsuhisa M et al. Diabetes Obes Metab. 2016;18:375-83.

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Abbreviated Prescribing Information

INDICATION: PLETAAL is indicated for 1) the improvement of the maximal and pain-free walking distances in patients with intermittent claudication, who do not have rest pain and who do not have evidence of peripheral tissue necrosis (peripheral arterial disease Fontaine stage II); 2) Prevention of recurrence of cerebral infarction (excluding cardiogenic cerebral embolism).

CONTRAINDICATION:
1) Known hypersensitivity to cilostazol or to any of the excipients; 2) Severe renal impairment: creatinine clearance of ≤ 25 ml/min; 3) Moderate or severe hepatic impairment; 4) Congestive heart failure; 5) Pregnancy; 6) Patients with any known predisposition to bleeding (e.g. active peptic ulceration, recent (within six months) haemorrhagic stroke, proliferative diabetic retinopathy, poorly controlled hypertension); 7) Patients with hemorrhage (e.g., hemophilia, increased capillary fragility, intracranial hemorrhage, hemorrhage in the digestive tract, hemorrhage in the urinary tract, hemoptysis, and hemorrhage in the vitreous body) as bleeding tendency may be increased; 8) Patients with any history of ventricular tachycardia, ventricular fibrillation or multifocal ventricular ectopics, whether or not adequately treated, and in patients with prolongation of the QTc interval; 9) Patients with a history of severe tachyarrhythmia; 10) Patients treated concomitantly with two or more additional antiplatelet or anticoagulant agents (e.g. acetylsalicylic acid, clopidogrel, heparin, warfarin, acenocoumarol, dabigatran, rivaroxaban or apixaban); 11) Patients with unstable angina pectoris, myocardial infarction within the last 6 months, or a coronary intervention in the last 6 months.

DOSAGE:
The recommended dosage of cilostazol is 100 mg twice a day. Cilostazol should be taken 30 minutes before breakfast and the evening meal. Taking cilostazol with food has been shown to increase the maximum plasma concentrations of cilostazol, which may be associated with an increased frequency of adverse reactions.

Further information on PLETAAL®, please see full Prescribing Information.
Further information available upon request:

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References:
1. *ACCF/AHA Practice Guidelines. Circulation 2013; 127(13):1425-43.*
2. *Barnett A et al. Curr Med Res and Opin 2004; 20(10): 1661-1670*
3. *TASC Working Group. Eur J Vasc Endovasc Surg 2000; 19 (Suppl A) S1-244*

PLE 201504 (printed in June 2015)

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Indication[2]

SAMSCA® is indicated for the treatment of clinically significant hypervolemic and euvolemic hyponatremia (serum sodium <125mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).

Abbreviated Prescribing Information

Presentation: Tablets 15mg or 30mg of tolvaptan. **Indication:** SAMSCA is indicated for the treatment of clinically significant hypervolemic and euvolemic hyponatremia (serum sodium <125mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH). **Dosage:** To be initiated in hospital due to need for evaluation of therapeutic response. The usual starting dose for SAMSCA is 15mg administered once daily without regard to meals. Increase the dose to 30mg once daily, after at least 24 hours, to a maximum of 60 mg once daily, as needed to achieve the desired level of serum sodium. Limit treatment duration to 30 days. **Contraindications:** Hypersensitivity to any component of Samsca. Urgent need to raise serum sodium acutely. Anuria. Hypovolaemic hyponatremia (worsening). Hypernatremia. Patients who cannot perceive or appropriately respond to thirst. Concomitant use of strong CYP3A inhibitors. Pregnancy. Breastfeeding. **Warnings and precautions:** Tolvaptan should be initiated and re-initiated in patients only in a hospital where serum sodium can be monitored closely. Tolvaptan has not been in a setting of urgent need to raise serum sodium acutely. For such patients, alternate treatment should be considered. Osmotic demyelination syndrome is a risk associated with too rapid correction of hyponatremia (eg., >12mEq/L/24 hours). Osmotic demyelination results in dysarthria, mutism, dysphagia, lethargy, affective changes, spastic quadriparesis, seizures, coma and death. Caution should be exercised to ensure patients have adequate access to water and not become overly dehydrated. Urinary outflow must be secured to avoid risk of developing acute urinary retention. If hepatic injury is suspected, discontinue SAMSCA. Avoid use in patients with underlying liver disease. Concomitant use of SAMSCA with other treatments for hyponatremia or other medicinal products that increase serum sodium concentration may result in a higher risk for developing rapid correction of serum sodium and is therefore not recommended. **Drug interactions:** Caution with: co-administration with CYP3A inhibitors, inducers and substrates. P-gp inhibitors, and digoxin. Concomitant use with hypertonic saline is not recommended. The effect of vasopressin analogues such as desmopressin may be attenuated in patients using such analogues to prevent or control bleeding when co-administered with SAMSCA. **Adverse reactions:** The following adverse reactions were reported (>2%) in clinical trials in hyponatremia: Dry mouth, constipation, thirst, asthenia, pyrexia, hyperglycemia, anorexia, pollakiuria or polyuria. See full package insert for further details and other undesirable effect. **Overdosage:** If overdose occurs, estimation of the severity of poisoning is an important first step. Treatment should involve symptomatic and supportive care, with respiratory, ECG and blood pressure monitoring and water/electrolyte supplements as needed. A profuse and prolonged aquaresis should be anticipated. Please refer to full package insert for further details.

References:
1. 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure – Web Addenda.
2. Samsca® package insert.

Further information available upon request.

Samsca® (tolvaptan)

SMC201701 (approved in Apr 2017)

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GET HbA_{1c} DOWN WITH CONTROL

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Abbreviated prescribing information

Tresiba® (insulin degludec) 100U (100 units/mL insulin solution for injection) in a prefilled pen (FlexTouch®) Consult Summary of Product Characteristics before prescribing.Presentation: Tresiba® FlexTouch®. All presentations contain insulin degludec. Tresiba® 100 units/mL – 1 mL of solution contains 100 units insulin degludec (equivalent to 3.66 mg). One pre-filled device contains 300 units of insulin degludec in 3 mL solution. **Indications:** Treatment of diabetes mellitus in adults. **Posology and administration:** Tresiba® is a basal insulin for once-daily subcutaneous administration at any time of the day, preferably at the same time of day. On occasions when administration at the same time of the day is not possible, Tresiba® allows for flexibility in the timing of insulin administration. A minimum of 8 hours between injections should be ensured. In patients with type 2 diabetes mellitus, Tresiba® can be administered alone, in combination with oral anti-diabetic medicinal products as well as in combination with bolus insulin. In type 1 diabetes mellitus, Tresiba® is to be used with short-/rapid-acting insulin. Administration by subcutaneous injection only. Tresiba® is available in 100 units/mL. For Tresiba® 100 units/mL a dose of 1–80 units per injection, in steps of 1 unit, can be administered. When initiating patients with type 2 diabetes mellitus the recommended daily starting dose is 10 units. Transferring from other insulins; in type 2 diabetes changing the basal insulin to Tresiba® can be done unit-to-unit, based on the previous basal insulin component; in type 1 diabetes the same applies apart from where transferring from twice-daily basal insulin or patients with an HbA1c <8.0%, the Tresiba® dose needs to be determined on an individual basis with a dose reduction considered. Doses and timing of concomitant treatment may require adjustment. In all cases doses should be adjusted based on individual patients' needs; fasting plasma glucose is recommended to be used for optimising glycaemic control. In elderly patients and patients with renal/hepatic impairment glucose monitoring should be intensified and the dose adjusted on an individual basis. Tresiba® comes in a pre-filled pen, FlexTouch®, designed to be used with NovoFine®/NovoTwist® needles. **Contraindications:** Hypersensitivity to the active substance or any of the excipients. **Special warnings and precautions:** Too high insulin dose, omission of a meal or unplanned strenuous physical exercise may lead to hypoglycaemia. Reduction of warning symptoms of hypoglycaemia may be seen upon tightening control and also in patients with long-standing diabetes. Administration of rapid-acting insulin recommended in situations with severe hyperglycaemia. Inadequate dosing and/or discontinuation of treatment in patients requiring insulin may lead to hyperglycaemia and potentially to diabetic ketoacidosis. Concomitant illness, especially infections, may lead to hyperglycaemia and thereby cause an increased insulin requirement. Transferring to a new type, brand or manufacturer of insulin should be done under strict medical supervision. When using insulin in combination with pioglitazone, patients should be observed for signs and symptoms of heart failure, weight gain and oedema. Pioglitazone should be discontinued if any deterioration in cardiac symptoms occurs. Patients must be instructed to always check the insulin label before each injection to avoid accidental mix-ups between the two strengths of Tresiba® and other insulins. Hypoglycaemia may constitute a risk when driving or operating machinery. **Pregnancy and lactation:** There is no clinical experience with use of Tresiba® in pregnant women and during breastfeeding. Animal reproduction studies with insulin degludec have not revealed any adverse effects on fertility. **Undesirable effects:** Refer to SmPC for complete information on side effects. Very common (≥1/10); common (≥1/100 to <. 1/10); uncommon (≥1/1.000 to

* Applies to the adult population only

< 1/100); rare (≥ 1/10.000 to < 1/1.000); very rare (< 1/10.000); not known (cannot be estimated from the available data). Very common: Hypoglycaemia. Common: Injection site reactions. Uncommon: Lipodystrophy and peripheral oedema. Rare: Hypersensitivity and urticaria. With insulin preparations, allergic reaction may occur; immediate-type allergic reactions may potentially be life threatening. Injection site reactions are usually mild, transitory and normally disappear during continued treatment.

References: 1. Rodbard HW, *et al.* on behalf of the BEGIN Once Long Trial Investigators. Comparison of insulin degludec with insulin glargine in insulin-naive subjects with Type 2 diabetes: a 2-year randomized, treat-to-target trial. *DIABETIC Medicine* 2013;30(11):1298–304. **2.** Bode BW, *et al.* on behalf of the BEGIN Basal–Bolus Type 1 Trial Investigators. Insulin degludec improves glycaemic control with lower nocturnal hypoglycaemia risk than insulin glargine in basal–bolus treatment with mealtime insulin aspart in Type 1 diabetes (BEGIN Basal–Bolus Type 1): 2-year results of a randomized clinical trial. *DIABETIC Medicine* 2013;30(11):1293–297. **3.** Tresiba® Packing Insert. **4.** Jonassen I, *et al.* Design of the novel protraction mechanism of insulin degludec, an ultra-long-acting basal insulin. *Pharmaceutical Research.* 2012;29(8):2104-2114.

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1 R. Gökea et al. Efficacy of vildagliptin and sitagliptin in lowering fasting plasma glucose:Results of a randomized controlled trial. Diabetes & Metabolism 41 (2015) 244—247. 2 Monnier L et al. Contributions of fasting and postprandial plasma glucose increments to the overall diurnal hyperglycemia of type 2 diabetic patients: variations with increasing lebels of HbA1c. Diabetes Care. 2003. 26 (3):8815. 3 E. Ferrannini et al. Fifty-two-week efficacy and safety of vildagliptin vs. glimepiride in patients with type 2 diabetes mellitus inadequately controlled on metformin monotherapy. Diabetes Obes Metab. 2009 Feb;11(2):157-66. 4 G. McInnes et al. , Cardiovascular and heart failure safety profile of vildagliptin: a meta-analysis of 17 000 patients. Diabetes, Obesity and Metabolism 17: 1085—1092, 2015.

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Study design[1]:
In a randomized, double-blind, controlled trial, patients with baseline HbA_{1c} 7.5-12% were randomized to receive either dapagliflozin 10 mg with metformin XR, dapagliflozin 10 mg alone or metformin XR alone for 24 weeks. The primary efficacy endpoint was the HbA_{1c} change from baseline at week 24. Change in total body weight was one of the key secondary endpoints, and blood pressure changes were measured as safety assessment.

BP=blood pressure. HbA_{1c}=glycated hemoglobin. SBP=systolic blood pressure. XR=extended-release

Reference: 1. Henry RR, et al. Int J Clin Pract. 2012;66(5):446-56.

xigduo™ XR abbreviated prescribing information:
Presentation: Dapagliflozin/metformin HCl extended-release film-coated tablet. **Indication:** An adjunct to diet and exercise to improve glycaemic control in adults with type 2 diabetes mellitus when treatment with both dapagliflozin and metformin is appropriate. **Dosage and Administration:** Orally (tablet to be swallowed whole) once daily with the evening meal. For initial therapy, dapagliflozin 10 mg and metformin extended-release 500 mg taken once daily, with metformin extended-release titratable to 2000 mg once daily. For add on combination therapy, dapagliflozin 10 mg and metformin extended-release at the dose already being taken, or the nearest therapeutically appropriate dose taken once daily. The maximum dose is dapagliflozin 10 mg/metformin extended-release 2000 mg once daily. **Contraindications:** Hypersensitivity to dapagliflozin, metformin HCl or excipients. Diabetic ketoacidosis, diabetic pre-coma. Moderate or severe renal impairment (CrCl <60 mL/min or eGFR <60 mL/min/1.73 m^2). Acute conditions with the potential to alter renal function such as: dehydration, severe infection, shock, or intravascular administration of iodinated contrast agents. Acute or chronic diseases which may cause tissue hypoxia such as: cardiac or respiratory failure, pulmonary embolism, recent MI, shock, acute significant blood loss, sepsis, gangrene, pancreatitis. During or immediately following surgery where insulin is essential, elective major surgery. Hepatic impairment. Acute alcohol intoxication, alcoholism. Lactation. **Precautions:** Lactic acidosis. Renal impairment. Hepatic impairment. Iodinated contrast agent administration. Hypoxic states. Surgery. Risk of volume depletion, hypotension or electrolyte imbalances. Urinary tract infections. Vitamin B_{12} levels. Alcohol intake. Ketoacidosis. Risk of hypoglycaemia. Concomitant insulin, sulphonylurea, beta-adrenergic blocker or ethanol. Pregnancy and lactation. Elderly. **Interactions:** Rifampicin. Mefenamic acid. Cationic drugs (eg, amiloride, digoxin, morphine, procainamide, quinidine, quinine, ranitidine, triamterene, trimethoprim, or vancomycin). Frusemide. Nifedipine. **Undesirable effects:** Dapagliflozin: Hypoglycaemia, genital infection, urinary tract infection, back pain, polyuria, renal impairment, decrease in CrCl, increased blood creatinine, volume depletion and mild GI symptoms (such as diarrhoea, nausea, vomiting, abdominal pain and loss of appetite). **Full local prescribing information is available upon request.** API.HK.XIG.0617

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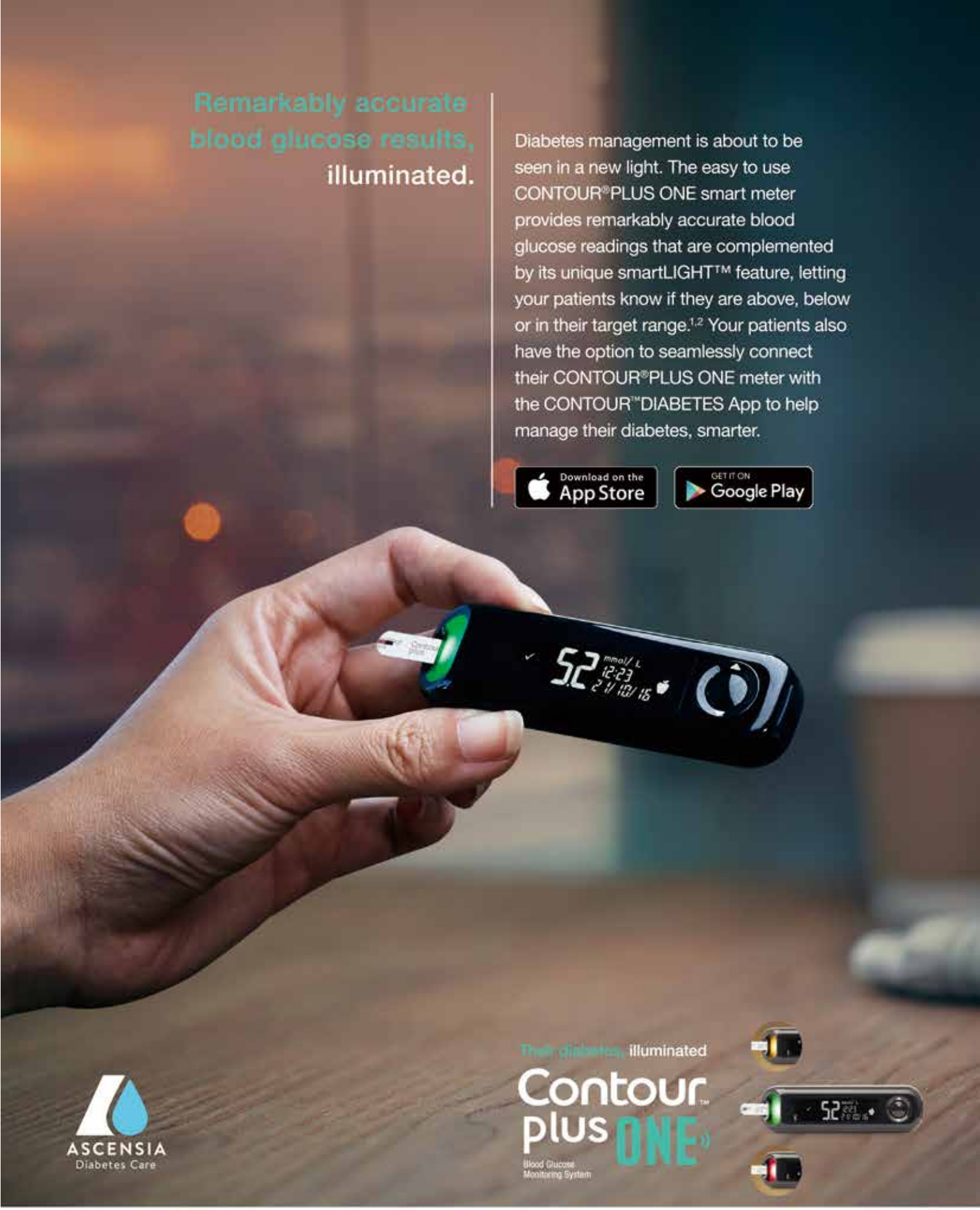

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References: 1. CONTOUR®PLUS ONE user guide. 2. Bailey T *et al.* Accuracy and user performance evaluation of a new blood glucose monitoring system in development for use with CONTOUR®PLUS Test Strips. Poster presented at the 15th Annual Meeting of the Diabetes Technology Society (DTS); 22–24 October, 2015; Bethesda, Maryland, USA.

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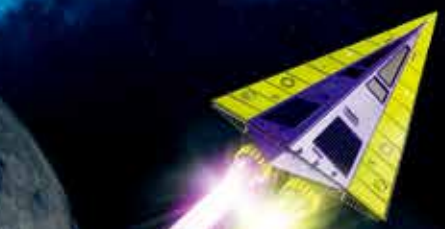

Selected Safety Information :
Indication: *Hypercholesterolaemia*- ATOZET is indicated as adjunctive therapy to diet for use in adults with primary (heterozygous familial and non-familial) hypercholesterolaemia or mixed hyperlipidaemia where use of a combination product is appropriate • patients not appropriately controlled with a statin alone • patients already treated with a statin and ezetimibe. ATOZET contains ezetimibe and atorvastatin. Atorvastatin has been shown to reduce the frequency of cardiovascular events (see section 5.1). A beneficial effect of ATOZET or ezetimibe on cardiovascular morbidity and mortality has not yet been demonstrated. *Homozygous Familial Hypercholesterolaemia (HoFH)*- ATOZET is indicated as adjunctive therapy to diet for use in adults with HoFH. Patients may also receive adjunctive treatments (e.g., low-density lipoprotein [LDL] apheresis). Contraindications: hypersensitivity to the active substances or to any of the excipients; therapy with ATOZET is contraindicated during pregnancy and breast-feeding, and in women of child-bearing potential not using appropriate contraceptive measures; ATOZET is contraindicated in patients with active liver disease or unexplained persistent elevations in serum transaminases exceeding 3 times the upper limit of normal (ULN). Precautions: Myopathy/Rhabdomyolysis, in post-marketing experience with ezetimibe, cases of myopathy and rhabdomyolysis have been reported. Most patients who developed rhabdomyolysis were taking a statin concomitantly with ezetimibe. Rhabdomyolysis has been reported very rarely with ezetimibe monotherapy; also, ATOZET contains atorvastatin, which is a HMG-CoA reductase inhibitor. Atorvastatin may in rare occasions affect the skeletal muscle and cause myalgia, myositis, and myopathy that may progress to rhabdomyolysis; a CPK level should be measured before starting treatment. If CPK levels are significantly elevated (>5 times ULN) at baseline, treatment should not be started; patients must be asked to promptly report muscle pain, cramps, or weakness especially if accompanied by malaise or fever. Liver Enzymes, liver function tests should be performed before the initiation of treatment and periodically thereafter; hepatic insufficiency; due to the unknown effects of the increased exposure to ezetimibe in patients with moderate or severe hepatic insufficiency, ATOZET is not recommended; interstitial lung disease; if it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued; diabetes mellitus: patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI>30kg/m², raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines; excipients; ATOZET contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. Adverse events: common adverse reactions (≥1/100, <1/10) include diarrhoea and myalgia; in controlled clinical trials, the incidence of clinically important elevations in serum transaminases (ALT and/or AST >3 X ULN, consecutive) was 0.8% for patients treated with ATOZET. These elevations were generally asymptomatic, not associated with cholestasis, and returned to baseline spontaneously or after discontinuation of therapy; please consult the full prescribing information for detailed adverse events.

Before prescribing, please consult the full prescribing information

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Selected Safety Information for JANUVIA, JANUMET and JANUMET XR:
Indications & Contraindications: JANUVIA (sitagliptin) is indicated as an adjunct to diet and exercise to improve glycaemic control in patients with type 2 diabetes mellitus as monotherapy or in combination with metformin, or a PPARγ agonist (e.g. a thiazolidinedione), or insulin (with metformin or pioglitazone), or a PPARγ agonist + metformin, when the current regimen, with diet and exercise, does not provide adequate glycaemic control. JANUMET (sitagliptin phosphate monohydrate/metformin HCl) and JANUMET XR (sitagliptin/metformin HCl extended-release) are indicated as an adjunct to diet and exercise to improve glycaemic control in adults with type 2 diabetes mellitus when treatment with both sitagliptin and metformin (including extended-release formulation) is appropriate. It should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. JANUMET and JANUMET XR is contraindicated in patients with renal disease or renal dysfunction, known hypersensitivity to sitagliptin phosphate, metformin hydrochloride or any other component of JANUMET and JANUMET XR, acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma. JANUMET and JANUMET XR should be temporarily discontinued in patients undergoing radiologic studies involving intravascular administration of iodinated contrast materials, because the use of such products may result in acute alteration of renal function. JANUMET XR should be promptly withheld in the presence of any conditions associated with hypoxemia, dehydration, or sepsis.
Precautions: Pancreatitis: In post-marketing experience there have been reports of acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, in patients taking sitagliptin. Patients should be informed of the characteristic symptom of acute pancreatitis: persistent, severe abdominal pain. Resolution of pancreatitis has been observed after discontinuation of sitagliptin, if pancreatitis is suspected, JANUVIA, JANUMET, JANUMET XR and other potentially suspect medicinal products should be discontinued. As is typical with other antihyperglycaemic agents, when JANUVIA, JANUMET and JANUMET XR was used in combination with a sulfonylurea or with insulin, medication errors to cause hypoglycaemia, the incidence of sulfonylurea- or insulin-induced hypoglycaemia was increased over that of placebo. Therefore, to reduce the risk of sulfonylurea- or insulin-induced hypoglycaemia, a lower dose of sulfonylurea or insulin may be considered. Renal impairment: JANUVIA – Dosage adjustment is required in patients with moderate renal impairment (Ccl 30-50 ml/min), severe renal impairment, JANUMET XR – contraindicated in moderate renal impairment. JANUVIA – No dosage adjustment for patients with mild to moderate hepatic insufficiency, not studies in severe hepatic insufficiency. JANUMET and JANUMET XR – avoided in such patients.
Selected Adverse Reactions: The incidence of selected gastrointestinal adverse experiences in patients treated with JANUVIA or placebo were: abdominal pain JANUVIA 2.3%, placebo 2.1%; nausea (1.4%, 0.8%); vomiting (0.6%, 0.3%); and diarrhea (3.8%, 2.5%). *Add-on Combination with a Sulfonylurea*: the drug-related adverse reaction reported at ≥1% and more commonly than with placebo was hypoglycemia. *Add-on Combination with Metformin and a PPARγ Agonist*: ≥1% and more commonly than with placebo were: headache, diarrhea, nausea, hypoglycemia, vomiting, upper respiratory tract infection, cough, fungal skin infection, peripheral edema. *Initial Combination Therapy with Metformin*: ≥5% and more commonly than with metformin alone were: diarrhea, dyspepsia, flatulence, vomiting, headache and nasopharyngitis. *Initial Combination Therapy with a PPARγ Agonist*: ≥1% and more commonly than with pioglitazone alone was coadministration decreased blood glucose and hypoglycemia. *Add-on Combination with Insulin*: ≥1% and more commonly than with placebo were: hypoglycemia, influenza and headache. *For Janumet XR (Clinical Trials) Sitagliptin and Metformin Immediate-Release Co-administration* most common (≥5%): Diarrhea, Upper Respiratory Tract Infection, Headache. *Sitagliptin in Combination with Metformin Immediate-Release and Glimepiride* (≥5%): upper respiratory tract infections, nasopharyngitis, peripheral edema and headache. *Sitagliptin in Combination with Metformin Immediate-Release and Insulin* (≥5%): hypoglycemia.

References: 1. Rosenstock J, Brazg R, Andryukhina N, et al. Efficacy and safety of sitagliptin/metformin fixed-dose combination therapy versus uptitrated metformin monotherapy in patients with type 2 diabetes mellitus inadequately controlled on metformin monotherapy: a randomized, double-blind, placebo-controlled trial. Diabetes Obes Metab. 2011;13(7):614-623. 2. Engel SS, Kaufman KD, Wagner JA, et al. Safety and tolerability of sitagliptin in clinical studies: a pooled analysis of data from 10,246 patients with type 2 diabetes. Diabetes Obes Metab. 2009;11(2):139-148. 3. Data on file, MSD & Ono. 4. Green JB, et al. Effect of Sitagliptin on Cardiovascular Outcomes in Type 2 Diabetes. New England Journal of Medicine. 2015 June. DOI.

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Course Director

Dr Alice Kong
Associate Professor, Department of Medicine and Therapeutics and Hong Kong Institute of Diabetes and Obesity, CUHK

Course Co-Directors

Prof Juliana Chan
Director, Hong Kong Institute of Diabetes and Obesity, CUHK
Chair Professor, Department of Medicine and Therapeutics, CUHK

Dr Andrea Luk
Associate Professor, Department of Medicine and Therapeutics and Hong Kong Institute of Diabetes and Obesity, CUHK

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