Diabetes Preventing the Preventables (DPP) Forum 2022

1 May 2022 • Hong Kong

Organizer:

亞洲糖尿病基金會
Asia Diabetes Foundation

Co-organizers:

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

APCDS
Asia Primary Care Diabetes Society

DIABETOLOGISTS & ENDOCRINOLOGISTS ALLIANCE

Supporting Organizations:

香港醫學會
The Hong Kong Medical Association

香港家庭醫學學院
The Hong Kong College of Family Physicians

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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 measure, manage and monitor in order to prevent premature death and disabilities for preserving the quality of life.

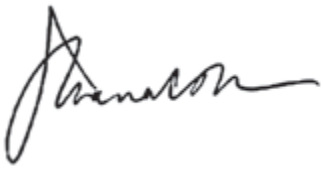
The most challenging aspect in managing diabetes is to help patients manage their disease for the rest of their life and to personalize treatment choices at different stages of the disease.

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.

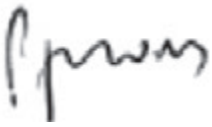
To this end, we have invited a faculty of experts and thought leaders with a diversity of experiences who will share with us their views and insights into this health care challenge.

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



Professor Alice Kong
Co-chairman

Professor Andrea Luk
Co-chairman

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THE HONG KONG MEDICAL ASSOCIATION

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The Hong Kong College of Family Physicians

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Professor Martin Wong

FACULTY MEMBERS

Winnie Siew Swee Chee

Professor, Department of Nutrition & Dietetics and Dean, School of Health Sciences, International Medical University, Malaysia

Dr. Winnie Chee is a Professor in the Department of Nutrition & Dietetics and Dean, School of Heath Sciences, International Medical University (IMU), Malaysia. Prof. Chee is the current President of the Malaysian Dietitians' Association and recognized for her expertise in evidence-based diet and lifestyle management of chronic diseases including obesity and diabetes. She is also a practicing dietitian at IMU Healthcare.

Tai Pang Ip

Consultant Endocrinologist, Department of Medicine, Tung Wah Hospital and Honorary Clinical Associate Professor, The University of Hong Kong, Hong Kong

Dr. Tai Pang Ip is a Consultant Endocrinologist in the Department of Medicine, Tung Wah Hospital and appointed as the Honorary Clinical Associate Professor of the Faculty of Medicine, The University of Hong Kong, Hong Kong.

Dr. Ip graduated from The University of Hong Kong in 1989. He received his specialist training in endocrinology at Queen Mary Hospital and the Garvan Institute of Medical Research, Sydney, Australia and became a Specialist in Endocrinology, Diabetes & Metabolism in 1997.

Dr. Ip is a well-known physician in the clinical therapeutics of metabolic disorders notably diabetes and osteoporosis. He has been very active in promoting personalized approach in the pharmacological treatment of diabetes and osteoporosis to the profession. In the past 30 years, Dr. Ip has delivered more than 200 lectures on osteoporosis & diabetes in local, regional and international scientific meetings. He is also very active in clinical research. He has been the principal investigators at the local centre for a number of multicentre international studies on diabetes and osteoporosis treatment (including the recent EMPA-REG, FIDELIO & FIGARO studies). He has authored more than 30 journal articles and conference abstracts.

FACULTY MEMBERS

Ingrid Yuen Man Kan

Senior Dietitian, Prince of Wales Hospital, Hong Kong

Ms. Ingrid Yuen Man Kan is a Senior Dietitian at the Prince of Wales Hospital, Hong Kong. She obtained the Master of Nutrition and Dietetics qualification from Australia. Since her graduation in 2004, she has been practicing in both private and public hospitals in Hong Kong. Her areas of expertise include nutrition for upper GI surgery, bariatric surgery, and pediatric nutrition. She is particularly interested in ketogenic diet for patients with refractory epilepsy.

Ms. Kan published a number of nutrition and recipe books in her career. Topics include on vegetarian diet, nutrition for pregnancy and also common myths of Hong Kong diet culture.

Naresh Kanumilli

General Practitioner, Northenden Group Practice, U.K.

Dr. Naresh Kanumilli has been a General Practioner in south Manchester for the past 18 years and he has a specialist interest in diabetes and cardiology. He is the Clinical Network Lead for Diabetes across Greater Manchester and East Cheshire. He has developed the diabetes strategy for Greater Manchester and is awaiting implementation. He is a Diabetes UK Clinical Champion. He has a very keen focus on management of chronic conditions in the community and hence has been actively involved in setting up and running community-based clinics both in cardiology and diabetes.

FACULTY MEMBERS

Paul Chi Ho Lee

Clinical Assistant Professor, School of Clinical Medicine, Department of Medicine, The University of Hong Kong, Hong Kong

Dr. Paul Chi Ho Lee is a Clinical Assistant Professor of the Department of Medicine, The University of Hong Kong, Hong Kong. He graduated from The University of Hong Kong in 2006, and became an endocrinologist in 2013. He joined the academia since 2015. Since then, his research focuses on the role of adiposity and inflammation in the development of various chronic diabetic complications, as well as identification of novel protein and/or genetic markers with prognostic importance to enhance better risk stratification in the clinical management of diabetes. Over the years, his research has established the roles of adipokines as useful prognostic markers in various diabetic complications among Chinese patients with T2DM, in particular adipocyte fatty acid-binding protein (AFABP) and fibroblast growth factor 21 (FGF21). He also has special interests in studying non-alcoholic fatty liver disease in type 2 diabetes. In 2017, he obtained the Croucher Foundation Fellowship to pursue his overseas training at the Garvan Institute of Medical Research, Sydney, Australia, working on the effects of exercise on NASH and hepatic fibrosis in MUP-uPA mice.

Adrian Liew

Senior Consultant and Director, The Kidney and Transplant Practice, Mount Elizabeth Novena Hospital, Singapore

Dr. Adrian Liew is a Senior Consultant Nephrologist at the Mount Elizabeth Novena Hospital in Singapore, and is a Scientific Leader with George Clinical. He is the current secretary of the International Society for Peritoneal Dialysis, and the current chair of the ISN Renal Disaster Preparedness Working Group. He is the immediate past Chair of the ISN Oceania-Southeast Asia Regional Board, ISN Councillor and ISN ExCom member. His research interests are in glomerular diseases, diabetic kidney disease and peritoneal dialysis. He is a member of the KDIGO Guideline Working Group for both glomerular diseases and diabetes management in chronic kidney disease. He also chairs the working group for the Asia-Pacific Society of Nephrology Clinical Practice Guidelines on Diabetic Kidney Disease.

FACULTY MEMBERS

Lee Ling Lim

Associate Professor, Department of Medicine, Faculty of Medicine, University of Malaya, Malaysia

Dr. Lee Ling Lim is a Consultant Endocrinologist and Head of the Diabetes Care Unit, University of Malay Medical Centre, Kuala Lumpur, Malaysia. As a clinician-scientist, Dr. Lim's major areas of interest are cardiometabolic medicine with translational and implementation science components. She is a member of the Scientific Work Groups of the ADA/EASD Precision Medicine in Diabetes Initiative and the WHO Global Diabetes Compact.

Dr. Lim has received several awards including the AOCO Rising Star Award, the USA Endocrine Society Outstanding Abstract Award, and the EFSD Albert Renold Fellowship. She is Academic Editor of PLoS One, as well as an Editorial Board Member of Diabetes & Metabolism and Primary Care Diabetes Europe.

Kit Man Loo

Diabetes Nurse Consultant, Diabetes & Endocrine Centre, Prince of Wales Hospital, Hong Kong

Ms. Kit Man Loo is a Diabetes Nurse Consultant working in the Diabetes & Endocrine Centre, Prince of Wales Hospital. She completed the Master of Primary Health Care in 2011 and obtained the Fellowship of the Hong Kong Academy of Nursing (Medicine – Diabetes) in 2012. She is now the Vice President of Association of Hong Kong Diabetes Nurses.

Ms. Loo has been involved extensively in diabetes patient education as well as training of health care professionals locally and mainland China. Her research interest is developing different patient educational programmes such as intensive insulin therapy programme and weight management programme.

FACULTY MEMBERS

Andrea On Yan Luk

Associate Professor, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Dr. Andrea On Yan Luk is an Associate Professor of the Department of Medicine and Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong. She is also the Medical Director (Non-Oncology) of the Phase 1 Clinical Trial Centre and serves as an honorary associate consultant at the Prince of Wales Hospital. Dr Luk completed her specialist training in endocrinology, reproduction and metabolism in 2007. Her research interests include epidemiology of diabetes and diabetes-related complications, young-onset diabetes, as well as translational studies of care models in people with diabetes. She has received multiple competitive grants to explore the aetiology and pathophysiological mechanisms underlying diabetes in young people. She has been an investigator of over 100 clinical trials. She has published more than 130 articles in peer-reviewed journals and has led the section on type 2 diabetes in youth in the 2021 edition of the International Diabetes Federation Atlas.

Sankar Dass Navaneethan

Professor of Medicine (Tenured), Associate Chief and Director of Clinical Research, Section of Nephrology, Baylor College of Medicine, U.S.A.

Dr. Sankar Dass Navaneethan is a Professor of Medicine (Tenured), Associate Chief and Director of Clinical Research at Section of Nephrology, and an Associate Director of the Institute of Clinical and Translational Research, at Baylor College of Medicine, Houston, Texas. He earned his medical degree from Madras Medical College, India, MPH degree (Epidemiology) from the University of South Carolina, USA and a Master's of Science degree in clinical research from Case Western Reserve University, Cleveland, Ohio. He completed his residency, chief residency and clinical nephrology fellowship at the University of Rochester, New York in 2008. He is a clinician scientist with major research interests in clinical trials in diabetic kidney disease, obesity and intentional weight loss in chronic kidney disease, cardiovascular disease in kidney disease, health services research and systematic reviews in Nephrology.

Professor Navaneethan has authored over 260 peer-reviewed publications and is currently involved in multiple clinical studies and has received independent funding from both NIH and Veterans Administration. He currently serves as an associate editor for the American Journal of Kidney Diseases since 2017, section editor for Current Opinion in Nephrology and Hypertension, associate editor of CardioRenal Medicine and has been appointed to editorial boards of other leading nephrology journals. He also served as a Co-Editor of Nephrology Self-Assessment Program (NephSAP-CKD), a premier publication of the American Society of Nephrology from 2015-2019. He also serve on the KDIGO guideline committee.

FACULTY MEMBERS

Risa Ozaki

Consultant, Division of Endocrinology & Diabetes, Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong

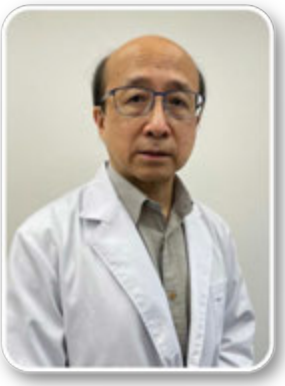
Dr. Risa Ozaki is a Consultant at the Prince of Wales Hospital and Honorary Clinical Associate Professor at the Department of Medicine and Therapeutics at The Chinese University of Hong Kong. She graduated from the University of Sheffield. She joined the Department of Medicine at Prince of Wales in 1996 after returning from the United Kingdom and received her Diabetology and Endocrinology training at the Prince of Wales Hospital in Hong Kong. Since 2000, she has been involved in conducting phase 1 to phase IV clinical trials for novel drug development involving more than 90 studies in the field of diabetes and obesity. She is currently the Endocrine Division Head for Clinical Services at Prince of Wales Hospital. Her area of interest is in the development of quality improvement programs to improve upon patient care by multidisciplinary care and team based approach.

William David Strain

Senior Clinical Lecturer, University of Exeter Medical School, U.K.

Dr. William David Strain is a Senior Clinical Lecturer at the University of Exeter Medical School, an honorary consultant in medicine for the older adult, Head of the academic department for healthcare for older adults and the chair of the British Medical Association's medical academic staff committee. Clinically, he runs a community diabetes service for the older adult, works as an in-patient stroke consultant, and participates in the chronic fatigue service.

FACULTY MEMBERS



Peter Chung Yip Tong

Specialist in Endocrinology and Clinical Associate Professor (Adjunct) The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, Hong Kong

Dr. Peter Chung Yip Tong is a Specialist in Endocrinology, Diabetes & Metabolism. He is a Clinical Associate Professor (Honorary) in the Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, and is a Past President of the Hong Kong Society of Endocrinology, Metabolism and Reproduction. He was also a Professor in the Department of Medicine & Therapeutics, The Chinese University of Hong Kong. Dr. Tong was a co-founder of Qualigenics Medical Limited, a technology transfer and health promotion programme company established by The Chinese University of Hong Kong and an industrial partner collaboration.

Dr. Tong has been a UK Medical Research Council Clinical Research Training Fellow, and also received a Peel Travelling Fellowship for his postdoctoral fellowship at the Hospital for Sick Children in Toronto, Canada.

Dr. Tong's research areas include disease management models of diabetes, diabetic kidney disease, obesity, the cellular mechanism of insulin resistance, and the use of traditional Chinese medicine in the treatment of diabetes. His work has been published in many international peer-reviewed scientific journals.

Martin Chi Sang Wong

Professor (Clinical), The Jockey Club School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Professor Martin Chi Sang Wong is a Specialist in Family Medicine and a Researcher in the field of cancer screening and prevention of chronic diseases. Professor Wong has composed over three hundred publications in international peer-reviewed journals, and received over 15 research awards for studies in his research area, including the prestigious "1st Distinguished Research Making Family Medicine Shine Award" by the World Organization of Family Doctors in 2018. He is a member of steering committees of multinational studies and advisory boards of the Government of the Hong Kong Special Administrative Region. He is currently the Convener of the Reference Frameworks for Diabetes Care and Hypertension Care for Adults in Primary Care Settings of the Department of Health, HKSAR Government. His enthusiasm to teaching has been well received by students and has been selected for the "Master Teacher" and the "Annual Teacher of the Year Award" for seven years. He was appointed as an Adjunct Professor of the Peking Union Medical College in March 2019; and Adjunct Professor of Global Health by the Peking University.

SCIENTIFIC PROGRAMME

1 May 2022 (Sunday)		
08:45 – 09:10	Registration	
09:10 – 09:15	Welcome remarks	Juliana Chung Ngor Chan, Hong Kong
Symposium 1 Nutrition in diabetes and NCD		**Co-chairs: Sarita Chan & Jimmy Wu**
09:15 – 09:45	Cultures and nutrition in diabetes prevention and management	Winnie Siew Swee Chee, Malaysia
09:45 – 10:15	Vitamin D supplement and chronic kidney disease	Sankar Dass Navaneethan, U.S.A.
Symposium 2 Controversies and care gaps		**Co-chairs: Elaine Chow & Alice Kong**
10:15 – 10:45	Pros and cons on ketogenic diet in preventing diabetes	Ingrid Yuen Man Kan, Hong Kong
10:45 – 11:15	Care gaps in osteoporosis and cardio-metabolic disease	Tai Pang Ip, Hong Kong
11:15 – 11:30	Break	
Symposium 3 ***(supported by Servier)***		**Co-chairs: Juliana Chan & Man Wo Tsang**
11:30 – 12:00	Real world evidence of sulphonlyureas usage in Asian patients with type 2 diabetes - The Joint Asia Diabetes Evaluation (JADE) Register	Lee Ling Lim, Malaysia
Symposium 4 ***(supported by Sanofi Hong Kong Ltd.)***		**Co-chairs: Alvin Cheung & Rose Ting**
12:00 – 12:30	Early intensification therapy of fixed ratio combination of basal analogue and GLP-1 RA versus Premix insulin	Paul Chi Ho Lee, Hong Kong
12:30 – 13:00	Glycaemic variability: What it is and why it matters	Peter Chung Yip Tong, Hong Kong
13:00 – 13:45	Break	
Symposium 5 ***(supported by Novo-Nordisk Hong Kong Ltd.)***		**Co-chairs: David Chao & Risa Ozaki**
13:45 – 14:45	How new insulin-based treatment therapy help achieving Time in Range, a new parameter in glycaemic goal	William David Strain, U.K.
Symposium 6 Implementation of precision and holistic care		**Co-chairs: Harriet Chung & Mary Kwong**
14:45 – 15:15	Does your patient have MODY?	Andrea On Yan Luk, Hong Kong
15:15 – 15:45	Nurse-coordinated targeted intervention program in diabetic kidney disease	Risa Ozaki & Kit Man Loo, Hong Kong
15:45 – 16:15	Latest HKG Framework on Management of Diabetes and Hypertension	Martin Chi Sang Wong, Hong Kong
16:15 – 16:30	Break	
Symposium 7 ***(supported by AstraZeneca Hong Kong Ltd.)***		**Co-chairs: Chung Ping Ho & Andrea Luk**
16:30 – 17:00	SGLT2i in management of diabetes and kidney disease	Naresh Kanumilli, U.K.
17:00 – 17:30	Asia Pacific Practice Guidelines for Diabetic Kidney Disease	Adrian Liew, Singapore
17:30 – 17:35	Closing remarks	Alice Pik Shan Kong, Hong Kong

ACADEMIC ACCREDITATIONS

College Name	CDE/CE/CEU/CME/CNE/CPD points
Association of Hong Kong Diabetes Nurses Limited (For ALL NURSES)	7
Hong Kong College of Community Medicine	Pending
Hong Kong College of Emergency Medicine	Pending
Hong Kong College of Paediatricians	6
Hong Kong College of Physicians	7
Hong Kong College of Radiologists	7
Hong Kong Dietitians Association	2 core & 3 non-core
Hong Kong Nutrition Association Limited	6
Hong Kong Physiotherapy Association Limited	5
Hong Kong Podiatrists Association	3
International Podiatrists Association of Hong Kong	10
MCHK CME Programme	5
Medical Laboratory Technologists Board	Pending
Pharmacy Central Continuing Education Committee	7
The College of Ophthalmologists of Hong Kong	Pending
The College of Surgeons of Hong Kong	Pending
The Hong Kong College of Anaesthesiologists	Pending
The Hong Kong College of Family Physicians	Pending
The Hong Kong College of Obstetricians and Gynaecologists	5
The Hong Kong College of Orthopaedic Surgeons	Pending
The Hong Kong College of Otorhinolaryngologists	Pending
The Hong Kong College of Pathologists	7
The Hong Kong College of Psychiatrists	6

SYMPOSIUM 1

Nutrition in diabetes and NCD

09:15 – 09:45

Cultures and nutrition in diabetes prevention and management

Winnie Siew Swee Chee

Professor, Department of Nutrition & Dietetics and Dean, School of Health Sciences, International Medical University, Malaysia

The prevalence of diabetes varies across ethnicities in many countries - for example it is highest among Malaysian Indians compared to Malays and Chinese. While genetics may play a role in the diabetes prevalence, cultural aspects play an integral part in influencing self-management of T2DM and approaches to education interventions by the healthcare provider. The success of dietary interventions at reducing HbA_{1c} and increasing diabetes knowledge reflects the value of offering culturally appropriate dietary recommendations and language-appropriate resources. However, cultural perspectives and experiences that influence dietary self-management also includes beliefs about food as medicine, food & social roles in the family, religion and health beliefs and attitudes. Dietitians need to be culturally competent to be able to individualize dietary management for the prevention and management of diabetes. This includes having a basic understanding of own culture, willingness to learn about the cultural practices of others and a positive attitude and readiness to accept and respect cultural differences.

09:45 – 10:15

Vitamin D supplement and chronic kidney disease

Sankar Dass Navaneethan

Professor of Medicine (Tenured), Associate Chief and Director of Clinical Research, Section of Nephrology, Baylor Colege of Medicine, U.S.A.

The prevalence of 25-hydroxyvitamin D (25[OH]D) is greater in individuals with CKD than in the general population. Deficiency of 25(OH)D is associated with poor outcomes including death in those with CKD. Low 25(OH)D concentrations contribute to a deficiency of $1,25(OH)_2D$, ultimately driving an increase in parathyroid hormone (PTH) levels and the development of secondary hyperparathyroidism (SHPT). $1,25(OH)_2D$ assists in the regulation of mineral homeostasis by mobilizing calcium and phosphate through gastrointestinal absorption. Thus, adequate $1,25(OH)_2D$ concentrations are needed for normal bone formation and mineralization.

The optimal serum 25(OH)D concentration for patients with CKD and the concentration at which patients with CKD are considered deficient/insufficient is not well defined but is generally considered to be the same as in the general population. Patients with CKD should be treated with nutritional vitamin D before initiating activated vitamin D therapy. Suppression of PTH via calcitriol and other vitamin D analogs have been the therapeutic mainstay for the treatment of SHPT. Multiple small randomized controlled trials reported benefits of these agents on improving biochemical endpoints, and adverse effects of hypercalcemia were also noted. It is important to note that no clinical trials have demonstrated the beneficial effects of calcitriol or vitamin D analogs on patient-level outcomes, such as cardiac events or mortality, and hence the optimal level of PTH in CKD G3a to G5 is not known. Two recent trials, PRIMO and OPERA, demonstrated significantly increased risk of hypercalcemia in patients treated with paricalcitol, compared with placebo, in the absence of beneficial effects on surrogate cardiac endpoints. Hence, current KDIGO clinical practice guidelines suggest that in adult patients with CKD G3a–G5 not on dialysis, calcitriol and vitamin D analogs not be routinely used (Grade- 2C). They also suggest that it is reasonable to reserve the use of calcitriol and vitamin D analogs for patients with CKD G4–G5 with severe and progressive hyperparathyroidism (Not graded).

SYMPOSIUM 2

Controversies and care gaps

10:15 – 10:45

Pros and cons on ketogenic diet in preventing diabetes

Ingrid Yuen Man Kan
Senior Dietitian, Prince of Wales Hospital, Hong Kong

The ketogenic diet is a high fat, adequate protein, low-carbohydrate diet that produces metabolic changes associated with the starvation state. The ketone bodies (acetoacetate, acetone, and beta-hydroxybutyrate) , created in the liver from fats can circulate in the blood and become the main source of energy for our body.

Pros of a ketogenic diet helps reduce seizure in pediatric patients with epilepsy. It can be an effective way of reducing blood glucose levels and achieving weight loss for people with type 2 diabetes in the short term (6 months).

However, ketogenic diet is not suitable for everyone, including children/adolescents and people with type 2 diabetes with specialized nutrition requirement.

10:45 – 11:15

Care gaps in osteoporosis and cardio-metabolic disease

Tai Pang Ip
Consultant Endocrinologist, Department of Medicine, Tung Wah Hospital and Honorary Clinical Associate Professor, The University of Hong Kong, Hong Kong

The "Three Highs & 1 Porous" have been well recognized as the most common chronic diseases facing our aging population. Despite an increasing publicity on these important health issues namely diabetes, hypertension, dyslipidaemia, obesity, and osteoporosis, there has been persistent suboptimal level of awareness both among the general public and among the practicing clinicians. Low level of awareness has resulted in a heavy demand on specialist care on the complications from these primary problems i.e. the atherosclerotic cardiovascular diseases, cerebrovascular diseases and fragility fractures.

Not only do we need to have an early diagnosis of these chronic metabolic conditions but we should also implement early and appropriate treatment for these metabolic diseases once they are diagnosed. Real world data from different parts of the world have shown that management of these chronic conditions have disappointedly been far from satisfactory. To improve the overall health, quality of life and longevity of our population, the concept of an early, aggressive, treat to target and comprehensive approach needs to be adopted for the management, or preferably, the prevention of these chronic metabolic diseases. The prevailing attitude of medical inertia in most of the practicing clinicians must be overcome.

SYMPOSIUM 3

(supported by Servier)

11:30 – 12:00

Real world evidence of sulphonlyureas usage in Asian patients with type 2 diabetes - The Joint Asia Diabetes Evaluation (JADE) Register

Lee Ling Lim

Associate Professor, Department of Medicine, Faculty of Medicine, University of Malaya, Malaysia

Of 463 million people with diabetes worldwide, over 50% reside in Asia. Created in 2007 by Prof. Juliana Chan and ADF, the Joint Asia Diabetes Evaluation (JADE) Register integrated big data from more than 100,000 patients in this region, in order to track secular trends, identify unmet needs and verify interventions in a naturalistic environment. Recently, this register explored clinical profiles and patterns of oral glucose-lowering drugs (OGLD) use in Asian patients with type 2 diabetes, with a focus on sulphonylureas use. The aim of this session is to provide general information about the Joint Asia Diabetes Evaluation (JADE) Register and share these new real-world evidences on treatment patterns in Asia.

The lecture will be performed by Dr. Lee Ling Lim (Malaysia) who participated to this real-world study and presented these results during International Diabetes Federation Congress in December 2022.

SYMPOSIUM 4

(supported by Sanofi Hong Kong Ltd.)

12:00 – 12:30

Early intensification therapy of fixed ratio combination of basal analogue and GLP-1 RA versus Premix insulin

Paul Chi Ho Lee

Clinical Assistant Professor, School of Clinical Medicine, Department of Medicine, The University of Hong Kong, Hong Kong

Both glucagon-like peptide 1 receptor agonists (GLP-1 RA) and insulin therapy are effective injectable therapies for the treatment of type 2 diabetes (T2D). Their actions are complementary to each other and their combination therefore provides an attractive therapeutic strategy. Indeed, in the latest guidelines from the American Diabetes Association, it was also recommended that combination therapy with a GLP-1 RA should be considered in patients on insulin therapy for greater efficacy and durability of treatment effect. Moreover, a fixed-ratio combination (FRC) product such as iGlarLixi consisting of glargine and lixisenatide, can be considered if patients are put on both GLP-1 RA and basal insulin therapy.[1]

However, intensification of treatment regimen is sometimes difficult in real-life due to multiple factors including clinical inertia of clinicians, patient preference, frequency of injections and convenience issues. The recently published Solimix study is a randomized controlled trial which demonstrated that in T2D patients who were sub-optimally controlled with basal insulin plus one or two oral anti-diabetic agents, the use of FRC for 6 months was non-inferior to premixed insulin therapy in glycaemic control and was superior in weight reduction, allowing a higher proportion of patients reaching their HbA_{1c} goals, and at the same time, without weight gain and hypoglycaemia.[2]

In this talk, the importance and difficulties during early intensification therapy in T2D patients will be presented. Moreover, the role of novel FRC as compared to other intensification strategies will also be discussed.

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2. Rosenstock J, Emral R, Sauque-Reyna L, Mohan V, Trescoli C, Al Sifri S, et al. Advancing Therapy in Suboptimally Controlled Basal Insulin-Treated Type 2 Diabetes: Clinical Outcomes With iGlarLixi Versus Premix BIAsp 30 in the SoliMix Randomized Controlled Trial. Diabetes Care. 2021.

12:30 – 13:00

Glycaemic variability: What it is and why it matters

Peter Chung Yip Tong

Specialist in Endocrinology and Clinical Associate Professor (Adjunct), The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong, Hong Kong

Clinicians have traditionally relied on the use of HbA_{1c} in assessing glycaemic control of patients with Diabetes, though increasingly scientific evidence has been highlighting this limitation. This is due to the inability of HbA_{1c} reading to highlight the day-to-day experience of patients with Diabetes, since HbA_{1c} provides a 3 months' reading on glucose level.[1] In addition, HbA_{1c} reading is also unable to predict nor address glycaemic variability and hypoglycaemia.[1]

With the use of technology such as Continuous Glucose Monitoring (CGM), patients can today leverage on such tools to better control their Diabetes. With patients achieving Time-in-Range (defined as 3.9 mmol/L to 10.0 mmol/L) as measured by CGM, studies have demonstrated that they can expect better outcomes in microvascular and macrovascular complications.[2-4]

In this presentation, the importance of considering glycaemic variability to improve glycaemic control will be discussed. Important aspects in using CGM and in interpretating the Ambulatory Glucose Profile report (derived through CGM use), from both a clinician and patient perspective will be shared. With the increasing use of ultra long-acting basal insulin analogue, the benefits of focusing on glucose variability/time-in-range will be addressed.[5]

Through this presentation, it is hoped that participants will understand the importance of moving beyond HbA_{1c} in helping their patients to improve their glycaemic control. With increasing research and scientific evidence supporting the consideration of glycaemic variability in managing diabetes, clinicians therefore need to be equipped with this new evidence and to incorporate such knowledge into their clinical practice.

References

1. Ajjan RA. How Can We Realize the Clinical Benefits of Continuous Glucose Monitoring? Diabetes Technol Ther. 2017 May;19(S2):S27-S36.
2. Battelino T, Danne T, Bergenstal RM, Amiel SA, Beck R, Biester T, et al. Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations From the International Consensus on Time in Range. Diabetes Care. 2019 Aug;42(8):1593-1603.
3. Beck RW, Bergenstal RM, Riddlesworth TD, Kollman C, Li Z, Brown AS, Close KL. Validation of Time in Range as an Outcome Measure for Diabetes Clinical Trials. Diabetes Care. 2019 Mar;42(3):400-405.
4. Lu J, Ma X, Shen Y, Wu Q, Wang R, Zhang L, et al. Time in Range Is Associated with Carotid Intima-Media Thickness in Type 2 Diabetes. Diabetes Technol Ther. 2020 Feb;22(2):72-78.
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SYMPOSIUM 5

(supported by Novo-Nordisk Hong Kong Ltd.)

13:45 – 14:45

How new insulin-based treatment therapy help achieving Time in Range, a new parameter in glycaemic goal

William David Strain
Senior Clinical Lecturer, University of Exeter Medical School, U.K.

Time in Range (TIR) is the new parameter to evaluate blood glucose control in patient with diabetes, to provide a more concise and meaningful information. TIR goes beyond HbA_{1c} because it illustrates glucose variability – the highs, lows, and in-range values that characterize life with diabetes.

International consensus regarding TIR was recently released and defined the concept of the time spent in the target range (3.9-10 mmol/L) while minimising time in hypoglycaemia. Furthermore, there is strong association between TIR and microvascular complications (retinopathy, nephropathy, and neuropathy) among diabetes patients with T2DM, when TIR increased, complications decreased.

Basal insulin is always considered to be an effective treatment for T2DM to maintain optimal glycaemic control. Insulin degludec, a new generation basal insulin with an ultra-long duration of action, providing flat and stable profile based on the pharmacological properties. The constancy of the steady-state profile of insulin degludec also offers a lower day-to-day variability leading more TIR.

Across different clinical trials, insulin degludec consistently demonstrated the benefit of lower hypoglycaemia risk. In a randomized, double-blind, treat-to-target crossover trial (SWITCH 2), among patients with type 2 diabetes switching from basal insulin. Insulin degludec demonstrated a significant reduction versus insulin glargine U100 in terms of rates of severe or BG-confirmed symptomatic hypoglycaemia.

Furthermore, from the perspective of TIR, in a randomized, crossover, multicentre trial (Switch Pro) comparing TIR with the use of insulin degludec U100 versus insulin glargine U100 in people with type 2 diabetes. Insulin degludec demonstrated superiority in TIR and reduced nocturnal time below range (TBR) versus insulin glargine U100. In conclusion, insulin degludec provides clinical benefits of effective glycaemic control with lower hypoglycaemia risk and more TIR.

SYMPOSIUM 6

Implementation of precision and holistic care

14:45 – 15:15

Does your patient have MODY?

Andrea On Yan Luk

Associate Professor, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Maturity-onset diabetes of the young (MODY) was first described in 1974 by Robert Tattersall in a case series of three families heavily affected by young-onset diabetes involving three generations, distinguished from type 1 diabetes by not requiring insulin therapy and not progressing to eye complications. It is now recognised that MODY is a form of monogenic diabetes arising from mutation in a single gene. Other forms of monogenic diabetes include neonatal diabetes, monogenic diabetes with multisystem syndromes, monogenic diabetes associated with severe insulin resistance or lipodystrophy, and mitochondrial diabetes. To date, 14 genes have been implicated in MODY, of which mutations in hepatic nuclear factor (HNF) 1A, 4A and glucokinase (GCK) are the most prevalent.

Accurate and timely detection of MODY is important because patients with MODY have different responses to glucose-lowering drugs and prognosis to patients with type 1 or type 2 diabetes. Some forms of MODY are associated with extra-pancreatic manifestations which require additional investigations. Given the hereditary nature of MODY, screening of at-risk family members will offer the opportunity of early diagnosis and treatment.

Around 3-4% of patients with young-onset diabetes have MODY or other forms of monogenic diabetes, and hence, MODY is uncommon but not rare. Early guidelines recommend MODY testing for people with age of diabetes diagnosis <25 years, have known parental history of diabetes and are non-insulin dependent. Additionally, low BMI has been identified as one of the discriminatory features of MODY. However, using these criteria to select cases for genetic testing will miss over 80% of patients with MODY. Risk calculator and screening algorithms have been developed to help improve testing efficiency.

In the past, Sanger sequencing has been the most frequently used method in clinical practice for identifying common MODY mutations. The disadvantage with Sanger sequencing is that it can only sequence one gene at a time. Next generation sequencing (NGS) is a high throughput method and is able to uncover variants in a much larger pool of genes simultaneously. With narrowing in the cost differential between Sanger sequencing and NGS, there is a trend towards using NGS to screen for genetic variants. Irrespective of the choice of sequencing method, a patient needs to be adequately counselled before genetic testing, and if necessary, to refer to a genetic counsellor especially if there are concerns about risks in children or future generation.

15:15 – 15:45

Nurse-coordinated targeted intervention program in diabetic kidney disease

Kit Man Loo
Diabetes Nurse Consultant, Diabetes & Endocrine Centre, Prince of Wales Hospital, Hong Kong

Risa Ozaki
Consultant, Division of Endocrinology & Diabetes, Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong

Diabetes is a leading cause for end-stage renal disease (ESRD) worldwide with diabetic kidney disease accounting for 50% of patients requiring renal replacement therapy. With the aging of the population, improved survival rates and growing numbers of diabetic patients, it is projected that the number of patients requiring renal replacement therapy will place a heavy burden on healthcare expenditure if the problem is not addressed.

Diabetic kidney disease (DKD) leading to ESRD is largely preventable if DKD is identified early and managed effectively. Many randomized trials have shown that control of multiple risk factors, the use of renin-angiotensin-aldosterone system (RAAS) inhibitors, sodium-glucose co-transporter 2 (SGLT-2) inhibitors and/or finerenone can improve cardiovascular and renal outcomes. However, despite the availability of drug treatment and the knowledge to improve clinical outcomes, the challenge remains on how to implement this in real world practice, particularly in busy clinic settings. Over recent years, it has been increasingly recognized that multidisciplinary team care approach in the management of chronic diseases have many advantages over conventional doctor-patient consultation. By re-structuring the delivery of care to that of a team based approach involving the collaboration between several parties: the physician, diabetes nurse educator and other allied health care providers including dietician, podiatrist, medical social worker, we can empower patients in taking a more active role in their self-care in diabetes management.

In our Centre, we have shown the effectiveness of team based approach in the management of patients with DKD. The care is coordinated by diabetes nurse educators. Strategies include the provision of a structured empowerment programme to engage the patients by briefing them on their individual risk factors and to set realistic treatment goals. This is followed by collaborative programmes with renal nurse, dietitian, patient peers and medical social worker. Besides providing knowledge and skill sets in diabetes care, the program also serves to identify any social or psychological issues that may hinder optimization of care. To facilitate this care delivery, advanced medical technology such as continuous glucose monitoring systems may be utilized for patients to have a better understanding of their own glucose patterns to guide them in initiating lifestyle modifications and readily accept more intensive diabetes treatment regimens.

The adoption of a team based care approach involving the expertise of various key medical healthcare providers, provides a much needed holistic management for DKD patients that help them attain treatment targets resulting in more favourable clinical outcomes.

15:45 – 16:15

Latest HKG Framework on Management of Diabetes and Hypertension

Martin Chi Sang Wong

Professor (Clinical), The Jockey Club School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

The Primary Healthcare Office of the Department of Health, The Hong Kong Government has formulated and constructed two Reference Frameworks (RF) aiming to providing recommendations for evidence-based care of diabetes and hypertension, respectively, among adults in the primary care setting. A Task Force on Conceptual Model and Preventive Protocols has been established under the working group on Primary Care, and proposed recommendations based on the latest evidence for clinical practice in the primary care settings of Hong Kong. They take references to different local and international authorities, guidelines, publications, and information, as well as inputs from the Expert Panel on Reference Frameworks. The aims of the Reference Frameworks are to promote health, prevent disease and tackle major health risks in the population; recommend interventions which are evidence-based and appropriate to primary care settings; use as common reference for co-ordinating different healthcare disciplines across Hong Kong; and empower patients and their carers.

Its Clinical Advisory Group (CAG) consists of academic professors, stakeholders from professional organizations, experts from primary care sector, and advocacy groups. Apart from being assembled to promote the development of the Reference Framework, the CAG is also committee to provide regular updates from the most recent scientific research.

This talk will discuss about some of the major changes in the guideline recommendations, including:

1) A revised drug treatment algorithm for diabetes patients, including the optimal second line therapy;
2) The various clinical targets of controlling diabetes;
3) A new section on continuous glucose monitoring;
4) Drug treatment for diabetes patients with hyperlipidemia;
5) Blood pressure measurement for establishing diagnosis of hypertension;
6) Techniques recommended for blood pressure measurement; and
7) The use of cardiovascular risk assessment tools in Hong Kong Primary Care

The speech will also share some of the important resources for physicians, allied healthcare professionals and the patients as the materials could be easily downloaded from the official website of the Primary Healthcare Office.

SYMPOSIUM 7

(supported by AstraZeneca Hong Kong Ltd.)

16:30 – 17:00

SGLT2i in management of diabetes and kidney disease

Naresh Kanumilli
General Practitioner, Northenden Group Practice, U.K.

Chronic kidney disease (CKD) has become one of the most common non-communicable diseases. As we are facing an aging population with multiple CKD risk factors i.e. diabetes, the early detection and intervention are the key to management to prevent progression to end stage kidney disease.

Sodium glucose co-transporter 2 inhibitors (SGLT2i) was first discovered more than 100 years ago but its clinical implication in diabetic kidney disease was only demonstrated in the last decade. This discovery revolutionized our understanding of the pathological mechanism and management in diabetic kidney disease.

In this lecture, we will share about the burden of CKD in with or without diabetes and its interconnectivity with heart disease, the importance of eGFR and microalbuminuria, and also the new update of clinical studies and international guideline for management.

17:00 – 17:30

Asia Pacific Practice Guidelines for Diabetic Kidney Disease

Adrian Liew

Senior Consultant and Director, The Kidney and Transplant Practice, Mount Elizabeth Novena Hospital, Singapore

Diabetic kidney disease is the leading cause of end-stage kidney failure requiring kidney replacement therapy in many parts of the Asia-Pacific region, presenting itself as a significant healthcare burden in many economies especially among the low- and middle-income countries. The heterogeneity in healthcare infrastructure, health seeking behaviour, cultures and resources in the Asia-Pacific region resulted in variability in the care of diabetic kidney disease, including screening, diagnostics, disease monitoring and evidence-based treatment. While international treatment guidelines are widely available, difficult accessibility to these guidelines and poor relevance to local context are significant obstacles to implementing these guidelines in many low resource settings. Costs of "gold-standard" diagnostic tests and "standard of care, evidence-based" medications are prohibitive in many countries, with lack of guidance for healthcare professionals in these situations. Consequently, the Asia-Pacific Society of Nephrology commissioned a working group to develop a set of clinical guidelines on diabetic kidney disease that will balance evidence-based recommendations with practical implementation practice points, which are clinically appropriate and easily implementable for the Asia-Pacific countries.

ACKNOWLEDGEMENTS

The Organizing Committee would like to extend their sincere thanks to the following companies for their support to the Diabetes Preventing the Preventables (DPP) Forum 2022.

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7 bowls

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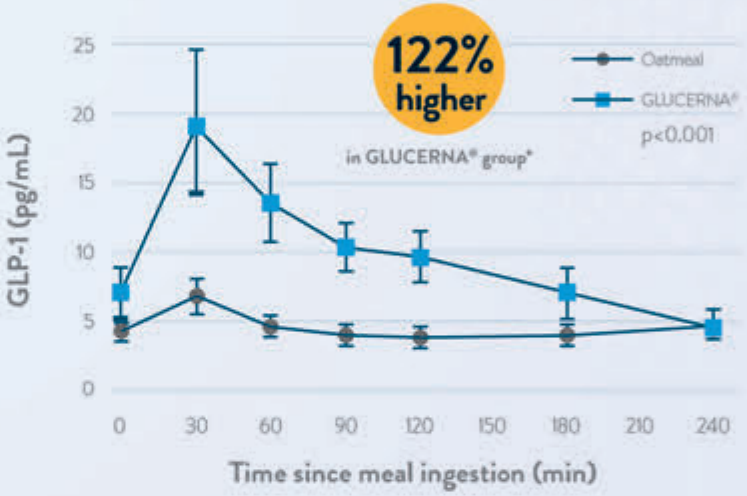
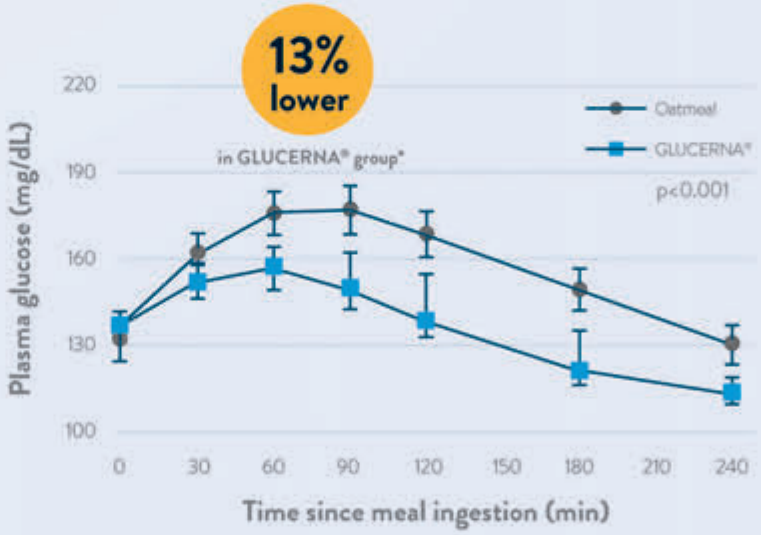


4-hour postprandial glucose level



*Difference in mean ± SEM values compared with oatmeal.

Study design[1]: A crossover, three-way, open-label clinical study of 22 overweight/obese patients with T2DM to evaluate postprandial effects of GLUCERNA® versus oatmeal on glucose and GLP-1 responses.

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1. Mottalib A, et al. Nutrients 2016; 8:443.

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Weight Loss Through tDNA Study with **GLUCERNA®** is Correlated with HbA1c Reduction[1]

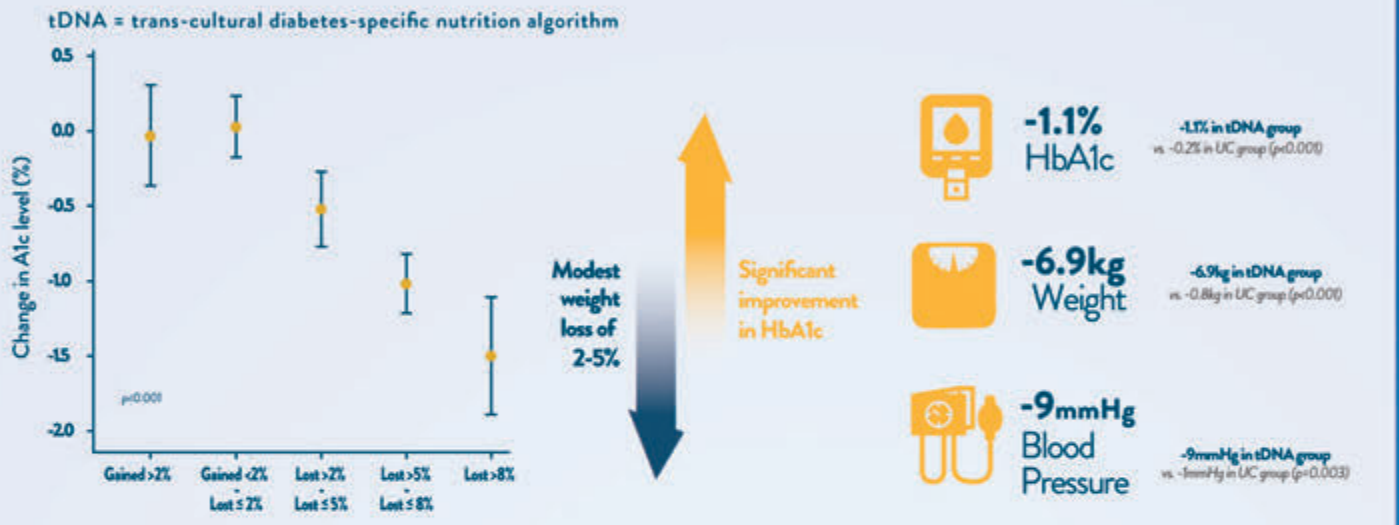

Figure 1. Graph of mean and SEM (mean±2 SE) between weight loss categories and change in glycated hemoglobin (A1c). *Significant association by regression analysis at p<0.05.

Study Design: 230 Malaysian patients with overweight/obesity, type 2 diabetes and A1c 7%-11% were randomized to receive usual care (UC) or UC with trans-cultural diabetes nutrition algorithm (tDNA) for 6 months. The tDNA subset was further divided into two counselling arms: motivational interviewing (MI) and conventional counselling (CC). tDNA patients received a structured low-calorie meal plan, diabetes-specific meal replacements and physical activity counselling; while the UC group received standard dietary and exercise advice through conventional counselling.
In this study, Glucerna family product (Glucerna SR) is used as intervention product.

Meal replacements (such as **GLUCERNA®**) are found to increase both short-term and long-term average weight loss by about **2.5kg** compared with prescription of conventional reducing diet with the same calorie goals.[2]

MOST CLINICALLY STUDIED DIABETES NUTRITIONAL BRAND IN THE WORLD

NUTRITION PROFILE MEETS RECOMMENDATIONS OF AMERICAN DIABETES ASSOCIATION[5]

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1.Chee WSS, et al. BMJ Open Diabetes Research & Care. 2017;5(1):e000384. 2.Heymsfield SB, van Mierlo CA, van der Knaap HC, et al. Weight management using a meal replacement strategy: meta and pooling analysis from six studies. Int J Obes Relat Metab Disord. 2003;27:537-49. 3.Devitt AA, et al. J Diabetes Res Clin Metab. 2012;1:20. 4.Devitt AA, et al. Advances in Bioscience and Biotechnology. 2013; 4: 1-10. 5.Diabetes Care 2021;44 (Suppl 1) 參合美國糖尿病協會之總水化合物、鈉、飽和脂肪及反式脂肪整建議 ☆Based on published clinical studies ▲此產品沒有根據《藥劑業及毒藥條例》或《中醫藥條例》註冊，為此產品作出的任何聲稱未沒有為進行該等註冊而接受評核。此產品並不供作診斷、治療或預防任何疾病之用。This product is not registered under the Pharmacy and Poisons Ordinance or the Chinese Medicine Ordinance. Any claim made for it has not been subject to evaluation for such registration. This product is not intended to diagnose, treat or prevent any disease. #Compared to a typical breakfast, as part of a diabetes management program including diet and exercise.

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1. Klaff L et al. Accuracy and User Performance of a New Blood Glucose Motoring System [published online ahead of print, 2020 Nov 26]. J Diabetes Sci Technol. 2020; https://doi.org/10.1177/1932296820974348. 2. CONTOUR®PLUS ELITE User Guide, November 2019, Revision 11.19. 3. Richardson JM et al. Clinical Relevance of Reapplication of Blood Samples During Blood Glucose Testing. Poster presented at the 20th Annual Diabetes Technology Meeting (DTM); November 12-14, 2020.

Date of preparation: March 2021. G.DC.03.2021.PP-CPLUS_ELT-GBL-0029

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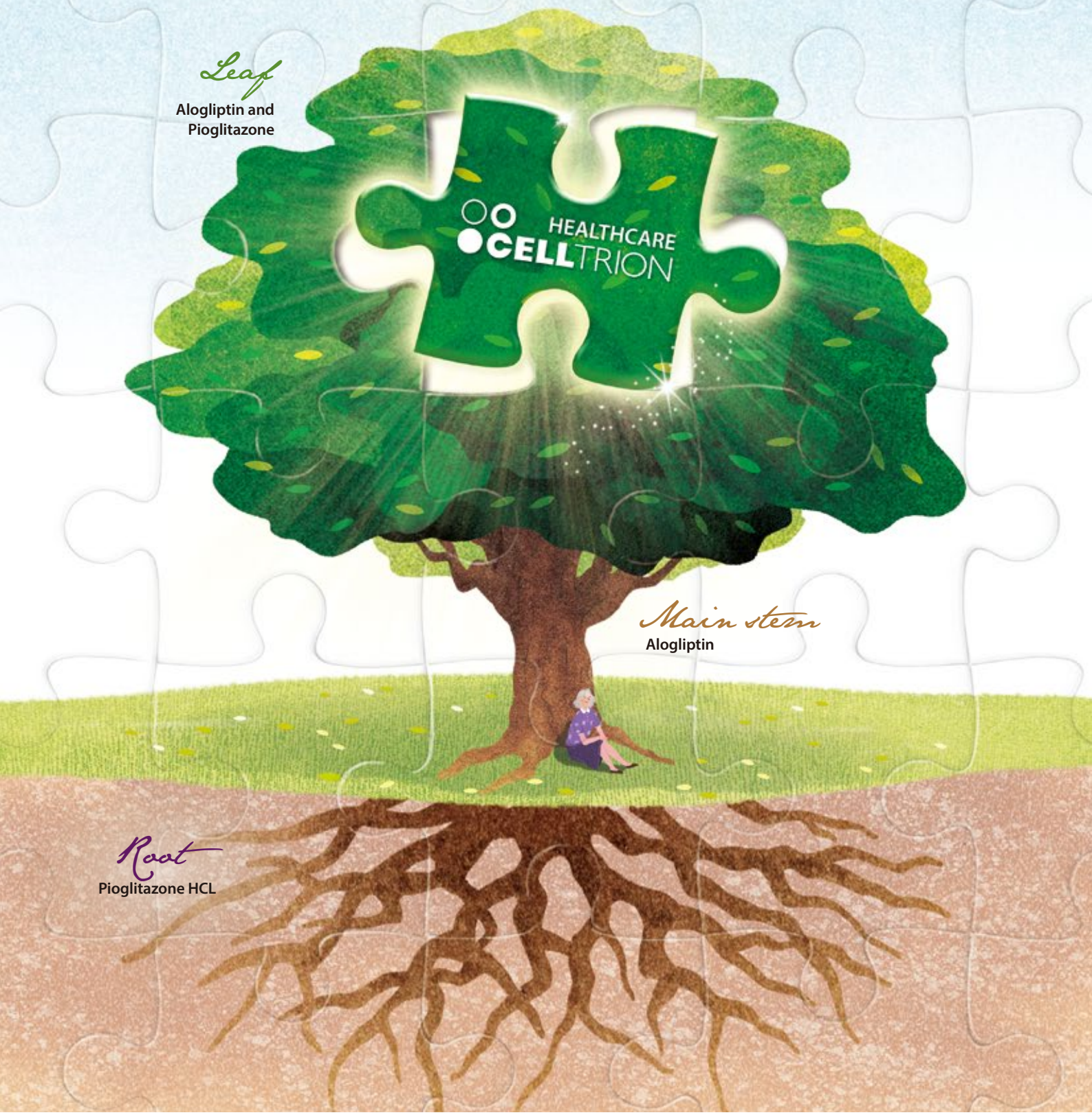

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References :

1. L. Pradelli et al. Clinical Nutrition 33 (2014) 785-792
2. Singer et al. (2009) ESPEN Guidelines on parenteral nutrition: Intensive Care. Clinical Nutrition 28: 387-400
3. Braga et al. (2009) ESPEN Guidelines on Parenteral Nutrition: Surgery. Clinical Nutrition, 28: 378-386
4. Biesalski HK. Gastroenterology 2009;137(5):92-104 http://www.espen.org/espenguidelines.html

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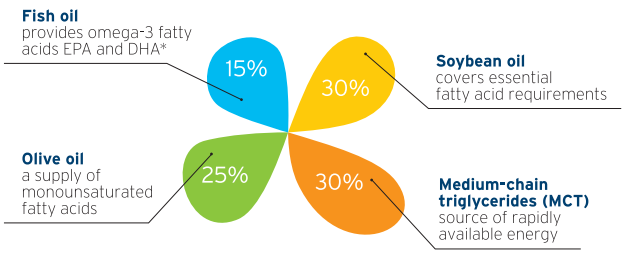

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- ↓**36% incidence of all-cause mortality** (p=0.01)
- ↓**39% myocardial infarction** (p=0.01)
- ↓**30% composite macrovascular disease endpoint** (p=0.02)

-36%
in overweight patients with newly diagnosed diabetes[1]

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Bisoprolol increases survival rate for NYHA III-IV patients, on top of standard therapy (diuretic + ACE inhibitor):

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- ↓**44% sudden death** (p=0.0011)
- ↓**20% all-cause hospital admissions** (p=0.0006)
- ↓**36% hospital admission for worsening heart failure** (p<0.0001)

-34%
in NYHA III-IV patients[2]

References: 1. UKPDS Research Group Lancet, 1998; 352:854-865; 2. CIBIS-II Investigators and Committees (1999) The Lancet;353:9-13.

Products: Concor 2.5mg, Concor 5mg film-coated tablets for oral use containing 2.5mg & 5mg bisoprolol fumarate, respectively. Indications: Concor® 5: Treatment of hypertension, coronary heart disease (angina pectoris), stable chronic heart failure (CHF) with reduced left ventricular systolic function in addition to ACE inhibitors, and diuretics, and optionally cardiac glycosides. Concor 2.5®: Treatment of stable chronic heart failure (CHF) with reduced left ventricular systolic function in addition to ACE inhibitors, and diuretics, and optionally cardiac glycosides. Posology: for hypertension or angina pectoris the dosage is 5mg bisoprolol fumarate once daily which may be increased to 10mg once daily if necessary. Maximum recommended dose is 20mg once daily. Treatment of stable CHF requires a titration phase, starting with a low dose (1.25mg once daily) and with gradual up-titration (2.5, 3.75, 5, 7.5, 10mg once daily at weekly consideration basis) according to tolerability. 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Contraindications: acute heart failure or during episodes of heart failure decompensation, cardiogenic shock, second or third degree AV block, sick sinus syndrome, sinoatrial block, symptomatic bradycardia or hypotension, severe bronchial asthma, severe forms of peripheral arterial occlusive disease or severe forms of Raynaud's syndrome, untreated phaeochromocytoma, metabolic acidosis, hypersensitivity to bisoprolol or to any of the excipients. Warnings and precautions for use: Use with caution in: bronchospasm (bronchial asthma, obstructive airways disease; concomitant bronchodilating therapy recommended); diabetes mellitus; symptoms of hypoglycemia can be masked; strict fasting; ongoing desensitization therapy; first degree AV block; Prinzmetal's angina; peripheral arterial occlusive disease; allergic reactions; phaeochromocytoma. Patients with psoriasis or with a history of psoriasis should only be given beta-blockers (e.g. bisoprolol) after a careful balancing of benefits and risks. Symptoms of thyrotoxicosis may be masked. In patients undergoing general anesthesia, the anaesthetist must be aware of beta-blockade. If it is thought necessary to withdraw beta-blocker therapy before surgery, this should be gradually and completed about 48 hours before anesthesia. Initiation of treatment of stable chronic heart failure with bisoprolol necessitates regular monitoring. There is no therapeutic experience in Concor in patients with Class II heart failure and concomitant insulin dependent type I diabetes mellitus, severely impaired kidney function, severely impaired hepatic function, restrictive cardiomyopathy, congenital heart disease, hemodynamically significant organic valvular disease. Age>80 years, myocardial infarction within 3 months. Ability to drive and use machines: may be impaired, particularly at start of treatment, upon change of medication, or in conjunction with alcohol. Interactions: Combinations not recommended: class I antiarrhythmic drugs (CHF), calcium antagonists of the verapamil and diltiazem type, centrally-acting antihypertensive drugs. Combinations to be used with caution: class I antiarrhythmic drugs (hypertension or angina pectoris), calcium antagonists of the dihydropyridine type, class III antiarrhythmic drugs, parasympathomimetic drugs, topical beta-blockers (e.g. eye drops), insulin and oral antidiabetic drugs, anesthetic agents, digitalis glycosides, non-steroidal anti-inflammatory drugs (NSAIDs), sympathomimetic agents, antihypertensive agents and other drugs with blood pressure lowering potential. Combination to be considered: mefloquine, monoamine oxidase inhibitors. Pregnancy and lactation: Use of bisoprolol not recommended. Adverse reactions: Very common: bradycardia (in CHF patients). Common: worsening of pre-existing heart failure (in CHF patients), dizziness, headache, gastrointestinal complaints such as nausea, vomiting, diarrhea, constipation; feeling of coldness or numbness in the extremities, hypotension, asthenia (in CHF patients), fatigue. Uncommon: AV-conduction disturbances, bronchospasm in patients with bronchial asthma or a history of obstructive airway disease, muscle weakness, muscle cramps, orthostatic hypotension, depression, sleep disorders; in patients with hypertension or angina pectoris: worsening of pre-existing heart failure, bradycardia, asthenia. Rare: increased triglycerides, increased liver enzymes (ALAT, ASAT) syncope, reduced tear flow, hearing disorders, allergic rhinitis, hypersensitivity reactions such as itching, flush, rash; hepatitis, potency disorders, nightmares, hallucinations. Very rare: conjunctivitis, alopecia; beta-blockers may provoke or worsen psoriasis or include psoriasis-like rash. Most common signs of overdose: bradycardia, hypotension, bronchospasm, acute cardiac failure, hypoglycemia. Date of product information: July 2016

Contents: Metformin HCl Indications: Reduction in risk or delay onset of type 2 DM in adult, overweight patients with IGT and/or IFG, and/or increased HbA1C who are at high risk for developing overt type 2 DM and still progressing towards type 2 DM despite implement intensive lifestyle change for 3 - 6 months. Treatment of type 2 DM in adults as an adjunct to adequate diet & exercise. Monotherapy or in combination w/ other oral antidiabetic medicines or insulin. Dosage: Adult w/ normal renal function (GFR ≥90 mL/min) Reduction in the risk or delay of the onset of type 2 DM Initially one 500-mg tab once daily w/ evening meal. After 10-15 days, adjust dose based on blood glucose measurements. Max: 2,000 mg once daily. Monotherapy in type 2 DM & combination w/ other oral antidiabetics agents Usual starting dose: One 500-mg tab once daily, or one 1,000-mg tab once daily. After 10-15 days, adjust dose based on blood glucose measurements. Max. recommended dose for 500 mg and 1g tab is 2g daily. Max. recommended dose for 750 mg tab is 1.5g daily. Combination with insulin Usual starting dose is one tablet XR 500 mg or XR 1 g once daily, while insulin dosage is adjusted on the basis of blood glucose measurements. For renal impairment patients A GFR should be assessed before initiation of treatment and at least annually thereafter. In patients at an increased risk of further progression of renal impairment and in the elderly, renal function should be assessed more frequently, e.g., every 3 - 6 months. Total max. daily dose of 2 g for GFR 60 - 89 mL/min, consider dose reduction for declining renal function. Total max. daily dose of 2 g for GFR 45 - 59 mL/min, review any increased risk of lactic acidosis before initiating metformin, whereas starting dose is at most half of max. dose. Total max. daily dose of 1 g for GFR 30 - 44 mL/min, review any increased risk of lactic acidosis before initiating metformin, whereas starting dose is at most half of max. dose. Pre- & Post-Prandial Advice: Swallow whole, do not chew/crush. Contraindications: Any type of acute metabolic acidosis (such as lactic acidosis, diabetic ketoacidosis), severe renal failure (GFR < 30mL/min), hepatic insufficiency, infectious diseases, following an IV urography or angiography, heart failure, recent MI, resp. failure, shock, persistent or severe diarrhoea, recurrent vomiting, alcoholism. Lactation. Special Precautions: Regular renal & blood sugar monitoring. Risk of lactic acidosis, most often occurs at acute worsening of renal function or cardiorespiratory illness or sepsis. Discontinue prior administration of iodinated contrast agents or surgery. May impair ability to drive or operate machinery in combination w/ other antidiabetic agents. Pregnancy. Elderly (for reduction of risk or delay of type 2 DM) Interactions: Iodinated contrast agents, corticosteroids, NSAIDs, ACE inhibitors, diuretics, sympathomimetics, alcohol, COX II inhibitors, angiotensin II receptor antagonists, OCT1 and OCT2 inhibitor/ inducer Presentations: XR tab 500 mg x 60's. 750 mg x 30's. 1,000 mg x 60's. Date of version: JUN 2018

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HK-MULCMC-00026 FEB2022

Januvia® (sitagliptin, MSD)

Choose JANUVIA® with CONFIDENCE*

Because time matters[1,^]

ONLY 1/3

T2DM patient typically achieved HbA1c target by 18 weeks on metformin monotherapy as demonstrated in the study[2#]

DON'T DELAY[1,^]

*Choose JANUVIA with confidence for your indicated T2DM patients uncontrolled with metformin[3]

Primary Endpoint: At week 18, mean change from baseline HbA1c was - 2.4% for sitagliptin/metformin FDC and - 1.8% for metformin monotherapy ($p < 0.001$).[2]

Study Design: This double-blind study (18-week Phase A and 26-week Phase B) randomized 1250 drug-naïve patients (defined as not on AHA therapy within the 4 months (or longer) preceding the screening visit) with T2DM (mean baseline hemoglobin A1c (HbA1c) 9.9%) to sitagliptin/metformin 50/500 mg bid or metformin 500 mg bid (up titrated over 4 weeks to achieve maximum doses of sitagliptin/metformin 50/1000 mg bid or metformin 1000 bid). Results of the primary efficacy endpoint (mean HbA1c reductions from baseline at the end of Phase A) were reported in the study.

HbA1c mean baseline was 9.9% ^Recommendations for treatment intensification for patients not meeting treatment goals should not be delayed[1]

Abbreviations: HbA1C=Haemoglobin A1C, T2DM=Type 2 Diabetes Mellitus, FDC=Fixed-dose Combination, AHA=antihyperglycaemic agents, BID=twice a day **Reference:** 1. American Diabetes Association Professional Practice Committee. 9. Pharmacologic approaches to glycemic treatment: Standards of Medical Care in Diabetes—2022. *Diabetes Care* 2022;45 (Suppl.1):S125–S143 2. Reasner C *et al. Diabetes Obes Metab* 2011; 13:644–52. 3. Hong Kong Prescribing Information (JANUVIA, MSD).

JANUVIA, JANUMET, JANUMET XR Selected Safety Information

Indication: • **JANUVIA** (***sitagliptin phosphate***) is indicated as an adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus as monotherapy or in combination with metformin, or a PPARγ agonist, or a sulfonylurea, or insulin (with or without metformin), or a sulfonylurea and metformin, or a PPARγ agonist and metformin, when the current regimen, with diet and exercise does not provide adequate glycemic control or due to contraindications or intolerance.• **JANUMET** (***sitagliptin phosphate/metformin HCl***) and **JANUMET XR** (***sitagliptin phosphate/metformin HCl extended release***) are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both sitagliptin and metformin is appropriate. **Contraindications:** • **JANUVIA, JANUMET and JANUMET XR** are contraindicated in patients who are hypersensitive to any components of these products and should not be used in patients with pancreatitis, type 1 diabetes, acute or chronic metabolic acidosis (lactic acidosis) or for the treatment of diabetic ketoacidosis (with or without coma). It should be temporarily discontinued in patients undergoing radiologic studies or withholding of intake for other surgical procedures. • **JANUMET and JANUMET XR** are contraindicated in patients with severe renal impairment (eGFR below 30 mL/min/1.73 m^2 or GFR < 30mL/min) or acute conditions with potential to alter renal function including dehydration, severe infection or shock. Lower JANUVIA dosages are recommended in patients with GFR < 45 mL/min, as well as in ESRD patients requiring hemodialysis or peritoneal dialysis. • **JANUMET and JANUMET XR** should be temporarily discontinued in patients undergoing radiologic studies or withholding of food or fluids for surgical or other procedures. • JANUMET XR has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for the development of pancreatitis while using JANUMET XR. • Metformin should be discontinued prior to or at the time of the imaging procedure and not restarted until at least 48 hours after, provided that renal function has been re-evaluated and found to be stable. **Precautions/ Warnings: (Post-marketing Experience/ General)** • **JANUVIA, JANUMET and JANUMET XR** have been reported with serious hypersensitivity reactions include anaphylaxis, angioedema, and exfoliative skin conditions including Stevens-Johnson syndrome. Acute pancreatitis with/without persistent and severe abdominal pain and bullous pemphigoid has been reported in patients taking sitagliptin. If any of the hypersensitivity reactions, pancreatitis with/ without symptoms, or any development of blisters, erosions or bullous pemphigoid is suspected, discontinue treatment, assess for other potential causes, and institute alternative treatment for diabetes. • Lower dosages are recommended in patients with GFR < 45 mL/min, as well as in ESRD patients requiring hemodialysis or peritoneal dialysis. • Hypoglycemia has been observed when sitagliptin and metformin (**JANUMET** and **JANUMET XR**) were used in combination with insulin or a sulfonylurea or ethanol. Consider a lower dose of sulfonylurea or insulin to reduce the risk of sulfonylurea- or insulin-induced hypoglycemia. • Lactic acidosis may occur in diabetes mellitus, hepatic impairment, excessive alcohol intake, when there is a significant tissue hypoperfusion and hypoxemia, and due to metformin accumulation during treatment with **JANUMET** and **JANUMET XR.** It is characterized by elevated blood lactate levels (>5 mmol/L), decreased blood pH, electrolyte disturbances with an increased anion gap, and an increased lactate/pyruvate ratio. If metformin-associated lactic acidosis is suspected, discontinue treatment immediately. **Adverse Events:** • The most common adverse experience in sitagliptin monotherapy reported was nasopharyngitis. The most common (>5%) adverse reactions due to initiation of metformin therapy are diarrhea, nausea/vomiting, flatulence, abdominal discomfort, indigestion, asthenia, and headache. The most common adverse reactions in the combined extended-release metformin or placebo and PPARγ agonist were hypoglycemia, diarrhea and nausea. ■ In the initial therapy of *Combination Therapy with Sitagliptin and Metformin IR,* patients may experience diarrhea, nausea, dyspepsia, flatulence, vomiting, headache and hypoglycemia. While in the add-on therapy, the incidences of pre-specified gastrointestinal adverse experiences in patients includes hypoglycemia, diarrhea, nausea, vomiting and abdominal pain. ■ *Sitagliptin in Combination with Metformin IR and a Sulfonylurea or Insulin:* patients may experience hypoglycemia, constipation and headache. ■ *Sitagliptin in Combination with Metformin IR and a PPARγ Agonist:* patients may experience headache, diarrhea, nausea, vomiting, hypoglycemia, upper respiratory tract infection, cough, fungal skin infection and peripheral edema. • **JANUVIA** was generally well tolerated in controlled clinical studies as both monotherapy and combination therapy, hypoglycemia may be experienced by patients.

Before prescribing, please consult the full prescribing information.

Januvia® (sitagliptin, MSD) Janumet® (sitagliptin/metformin, MSD) ONCE-DAILY Janumet XR® (sitagliptin/metformin extended-release, MSD)

MSD

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Tel: (852) 3971 2800 Fax: (852) 2834 0756
Website: www.msd.com.hk

HK-DIA-00146 Feb/2022

Increasing FREE WATER CLEARANCE with SAMSCA®

SAMSCA® is effective at raising serum Na^+ in HF patients over 30 days[1]

Pooled analysis of SALT-1 and SALT-2, mean change from baseline vs. placebo (P<0.0001)*

Day 4	Day 30
3.5 vs. 0.5 mEq/L	6.6 vs. 2.4 mEq/L

SAMSCA® has a significant effect on fluid balance in HF patients[1]

Mean net fluid balance at day 1 in patients with baseline serum Na^+ <135mEq/L (p=0.0027)*

SAMSCA® -1860mL vs. Placebo -787mL

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).

*Results from pooled analysis of SALT-1 and SALT-2 in congestive heart failure subgroup. SALT-1 and SALT-2 were two phase 3 randomized, double-blind trials in which patients with chronic or intermittent hyponatremia (<135 mEq/L) in a euvolemic or hypervolemic state were randomized to SAMSCA® (n=225) or placebo (n=223). SAMSCA® was started at 15 mg daily, then daily or less frequent titration to 30 mg daily or 60 mg daily as dictated by the individual subject serum sodium response. The two primary end points for all patients were the change in the average daily area under the curve for the serum sodium concentration from baseline to day 4 and the change from baseline to day 30.[1]

References: **1. Integrated Summary of Efficacy of Tolvaptan for the Indication of Hyponatremia (2007). Otsuka Pharmaceutical Development & Commercialization, Inc.**
2. SAMSCA® (tolvaptan) Hong Kong Prescribing Information revised Mar 2019.

HF: Heart failure; Na^+: Sodium

Abbreviated Prescribing Information

SAMSCA (tolvaptan) 15 mg & 30 mg oral tablets. INDICATION: treatment of clinically significant hypervolemic and euvolemic hyponatremia [serum sodium <125 mEq/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: Patients should be in a hospital for initiation and re-initiation of therapy to evaluate the therapeutic response. Too rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) can cause osmotic demyelination. Recommended starting dose: 15 mg once daily. Dosage may be increased at intervals ≥ 24 hr to 30 mg once daily, and to a maximum of 60 mg once daily. Limit use to 30 days to minimize the risk of liver injury. Avoid fluid restriction during the first 24 hours of therapy. CONTRAINDICATION: Autosomal Dominant Polycystic Kidney Disease; Urgent need to raise serum sodium acutely; Inability of the patient to sense or appropriately respond to thirst; Hypovolemic hyponatremia; Concomitant use of strong CYP 3A inhibitors e.g. clarithromycin, ketoconazole, itraconazole; Anuric patients; Hypersensitivity. SPECIFIC POPULATIONS: Only used during pregnancy if potential benefits justify the risk to the fetus. Avoid use in patients with underlying liver disease. Not recommended for patients with CrCl <10 mL/min. WARNINGS AND PRECAUTIONS: Avoid coadministration with moderate CYP 3A inhibitors. Too rapid correction of serum sodium can cause serious neurologic sequelae. Liver injury & discontinue treatment when patients develop symptoms indicative of liver injury. Dehydration and Hypovolemia. Co-administration with hypertonic saline not recommended. Avoid co-administration with CYP 3A inducers. Samsca may be increased when co-administrated with P-gp inhibitors. Monitor sign of hyperkalemia and cautious when co-administrated with drugs that increase serum potassium. ADVERSE REACTIONS: Thirst, dry mouth, asthenia, constipation, pollakiuria or polyuria, & hyperglycemia, pyrexia & anorexia. DRUG INTERACTIONS: CYP 3A inhibitors, grapefruit Juice, P-gp Inhibitors, rifampin and other CYP 3A Inducers, concomitant use increases digoxin AUC/Cmax. For details, please refer to the full prescribing information which is available upon request (HK REVISED: 03/2019).

HKOP-SAM-202202-001

Samsca® (tolvaptan)

Otsuka Otsuka Pharmaceutical (H.K.) Ltd.
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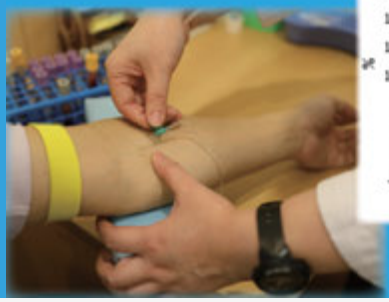
香港中文大學
The Chinese University of Hong Kong

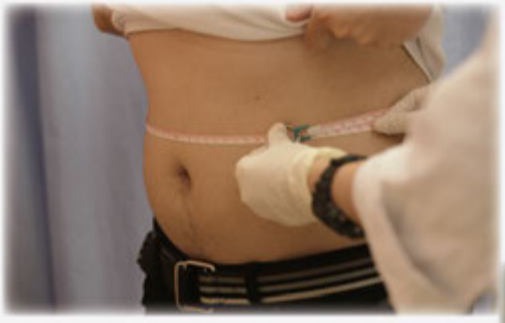
香港糖尿病及肥胖症研究所
HONG KONG INSTITUTE OF DIABETES AND OBESITY

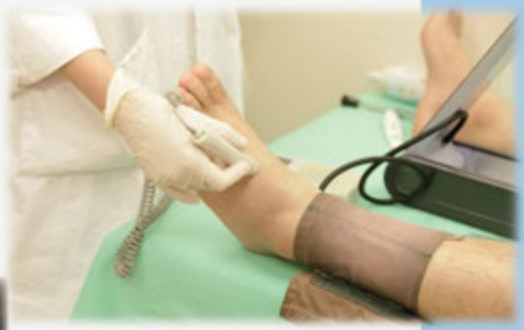
YAO CHUNG KIT DIABETES ASSESSMENT CENTRE

- First university-affiliated diabetes centre in Hong Kong
- Over 23,000 people with or at risk of having diabetes have been benefited since 2007
- Affordable risk stratification programmes for patients with diabetes in the community
- Evidence-based comprehensive assessment services and education programmes to complement medical care

- **Diabetes Prediction and Diagnosis Service**
- **Cardiovascular Risk Assessment**
- **Diabetic Complications Assessment**
- **Diabetes Education and Empowerment Programme**
- **Genetic Testing and Other Services**







For referral and service booking, please contact -

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亞洲糖尿病基金會
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