澳門介入診療學會
學術年會2023

Associação de Diagnóstico e de Terapêutica de Intervenção de Macau

ANNUAL SCIENTIFIC CONFERENCE 2023

2023/02/12

MGM MACAU GRAND BALLROOM

澳門介入診療學會
Welcoming Speech

All creations are reborn on New Year's Day. I wish you propitiation and prosperity in this new lunar year.

Over the last three years, the Macao government has aligned with residents to combat the COVID-19 outbreaks. At this moment, our daily life finally returns to normal. Therefore, it is an ideal time for our association (ASSOCIAÇÃO DE DIAGNÓSTICO E DE TERAPÊUTICA DE INTERVENÇÃO DE MACAU, ADTIM) to start organising a reunion to unify the strength of the medical specialists in Macao.

The purpose of establishing our association is to create a platform to communicate, exchange new diagnostic techniques, and update innovative treatments or strategies in different medical fields. Notably, the Macao medical community has already found various specialist associations that conduct medical academic activities effectively. However, our association has recruited elites from diverse specialties, for instance, internal medicine (including cardiology, gastroenterology, and neurology), radiology, neurosurgery, and general surgery. The association aims to open the intellectual door of each specialty and set up the clinical discipline and protocol in different specialties.

Though we are novices in initiating academic conferences, we strive for excellence in organising this activity. By contributing our effort to cultivating our medical specialists, the local medical specialists could be more competent and sophisticated. We expect that in the near future, specialists from different specialties will work jointly to improve the medical level and to provide a more qualified medical service. So, let's enrich our medical knowledge and grow up together.

In this critical moment of the rabbit new year, our association wish a happy new year, good luck, good health and good fortune to every attendant. I hope all participants enjoy our meeting today and, more importantly, acquire new knowledge from this academic activity.

LAM U Po
President

Organizing Committee

Chairperson

Dr. LAM U Po
Dr. JIN Chun
Dr. Mario EVORA

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Dr. CHANG Tou
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Dr. LEUNG Ki
Dr. MOK Ka Pou
Dr. NG Ka Kei
Dr. TAM Man Pan
Dr. TAM Weng Chio
Dr. WONG U Kam

Agenda

SECTION 1	**Chairperson: JIN Chun, KONG Soi Chau, TAM Man Pan**
10:00-10:30	Wireless pacing device experience in CHCSJ - LAM U Po (*Macau*)
10:30-11:00	熱消融治療肺部亞實性結節專家共識（2021年版）解讀 - 范衛君 (*Mainland China*)
11:00-11:30	Advancing the Management of Heart Failure with SGLT2i - TSANG Chun Fung (*Hong Kong*)
11:30-12:00	Opening Ceremony
12:00-13:30	Lunch
SECTION 2	**Chairperson: NG Hou, CHONG Keng Sang, CHANG Tou**
13:30-14:00	Management of Heart Failure Hospitalisation: Role of SGLT2 inhibitors and Practical Consideration - TSE Hung Fat (*Hong Kong*)
14:00-14:30	Perquisites for Extremely High Risk ACS PCI - LAM Ho (*Hong Kong*)
14:30-15:00	Innovative Approach to Cholesterol Control - YIU Kai Hang (*Hong Kong*)
15:00-15:30	Tea break
SECTION 3	**Chairperson: PON Monica, LEUNG Ki, KONG Kuan Kei**
15:30-16:00	What is the best Angina Management - TAM Weng Chio (*Macau*)
16:00-16:30	Are Statin enough? When to consider PCSK9 inhibitors - WONG Chi Yuen (*Hong Kong*)
16:30-17:00	Treating patients with AF undergoing PCI: finding the sweet spot of treatment - LEONG Iat Lon (*Macau*)
17:00	Closing remarks

Category

Wireless pacing device experience in CHCSJ

Dr.LAM U Po

U Po, Lam, MD, is a cardiovascular medicine specialist, consultant of Cardiology in Centro hospitalar de Conde S.Januario, Macao , graduated from Jinan University of Medicine Faculty on 1990, also got master degree in Medicine on 2004 in the same university . His cardiological specialist training follow associated with Peking Fu Wai Cardiovascular hospital on 1996,2005, pacing training with S Francisco Xavier hospital Lisbon on 1997, interventional course with Hong Kong Queen Elizabeth hospital on 2011,2014. His clinical interest is interventional cardiology, acute coronary syndrome and critical heart disease, otherwise, he facilitated in pacing and ICD implantation. Dr.Lam has lots social activities such as president of Macao physician society, vice president of Macao cardiology association, has authored and co-authored over ten publications in Chinese Medicine Journal, HKCC journal, etc.

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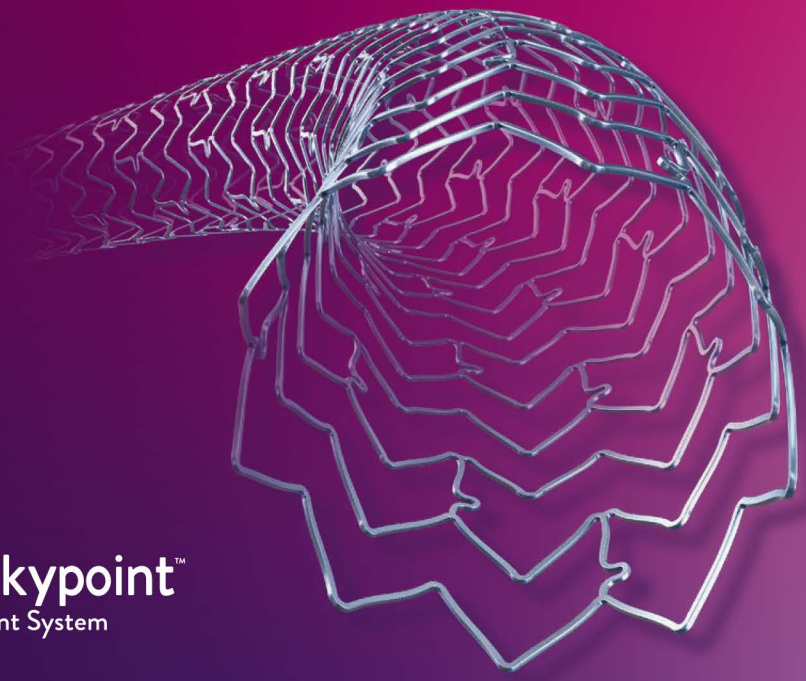

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XIENCE Skypoint™ Stent delivers the broadest expansion range in the latest generation XIENCE[1], the DES that consistently delivers successful outcomes – not only in the cath lab, but far beyond.[2]

1. Data on File at Abbott - XIENCE Skypoint™ Stent vs. XIENCE Sierra™ Stent. 2. Zanchin, C. et al. *J Am Coll Cardiol Intv. J Am Coll Cardiol Intv.* 2019;12(17):1665-1675. Serruys P, et al.*N Engl J Med.* 2010;363:136-146. Shiomi H, et al. *J Am Coll Cardiol Interv.* 2019;12:637-647. Kufner S, et al. Circulation. 2019:139(3):325-333.

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熱消融治療肺部亞實性結節專家共識 2021年版 解讀

范衛君 主任醫師 博士研究生導師

中山大學附屬腫瘤醫院 微創介入治療科 - 主任
中國醫師協會腫瘤消融治療技術專家組 - 組 長
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《Journal of Cancer Research and Therapeutics》雜誌 副主編
2019年第三屆“國之名醫·優秀風範”

Go lower and longer for better outcomes

Repatha® (evolocumab)

Lowering LDL-C with Repatha® offers increased CV risk benefits over time[1]

Reductions in the key secondary composite endpoint of CV death, MI or stroke in the FOURIER study*:

In the first year (0-12 months) — 16% RRR (HR: 0.84 (95% CI: 0.74–0.96))

Beyond the first year (12–36 months) — 25% RRR (HR: 0.75 (95% CI: 0.66–0.85))

Repatha® has demonstrated consistent safety over a 5-year treatment period[2]

Safety and tolerability outcomes in the 5-year OSLER-1 study:

- Safety profile comparable to placebo
- No neutralizing antibodies detected

Repatha® is supported by well-established worldwide clinical experience[3,4]

Since launch, >1,000,000 patients have benefited from the sustained efficacy and consistent safety of Repatha®,[3] including >41,000 patients in clinical trials[4]

*The composite of CV death, MI or stroke was a key secondary endpoint of the study; data presented are from prespecified exploratory analysis.[1]

FOURIER study design: The FOURIER study was a double-blind, randomized, placebo-controlled, event-driven trial in 27,564 adult subjects with established CVD and with LDL-C 1.8 mmol/L and/or non-HDL-C 2.6 mmol/L despite high- or moderate-intensity statin therapy. Subjects were randomly assigned to receive Repatha® (140 mg every 2 weeks or 420 mg once monthly) or placebo. The median follow-up duration was 26 months.[1] The risk of the primary efficacy endpoint (a composite endpoint of time to CV death, MI, hospitalization for unstable angina, stroke, or coronary revascularization) was reduced by 15% (HR: 0.85; 95% CI: 0.79–0.92; p<0.001).[1]

OSLER-1 study design: OSLER-1 was an open-label, 4-year extension study following a 1-year randomized treatment period.[2] 1,125 subjects enrolled in one of five phase 2 studies of Repatha® were randomized to SOC or SOC plus Repatha® 420 mg monthly during the randomized period; 1,151 patients progressed to the all-Repatha® period (420 mg monthly, plus SOC) for year 2 and beyond.[2] The primary objective was characterization of the long-term safety and tolerability of Repatha®; subjects were followed for up to 5 years.[2]

Abbreviations

CI, confidence interval; CV, cardiovascular; CVD, cardiovascular disease; HDL-C, high density lipoprotein cholesterol; HR, hazard ratio; LDL-C, low density lipoprotein cholesterol; MI, myocardial infarction; RRR, relative risk reduction; SOC, standard of care.

Repatha® (Evolocumab) Abbreviated Prescribing Information

Presentation: Solution for injection; pre-filled autoinjector 140 mg/mL. **Indications:** Primary hypercholesterolaemia (heterozygous familial and non familial) or mixed dyslipidaemia: As an adjunct to diet: In combination with a statin or statin with other lipid-lowering therapies in adult patients unable to reach LDL C goals with the max tolerated dose of a statin or, alone or in combination with other lipid-lowering therapies in adult patients who are statin-intolerant or for whom statin is contraindicated. Homozygous familial hypercholesterolaemia: In combination with other lipid-lowering therapies in adults and adolescents ≥12 years. Established atherosclerotic cardiovascular disease (myocardial infarction, stroke or peripheral arterial disease): In adult as an adjunct to correction of other risk factors: In combination with max tolerated dose of statin with or without other lipid-lowering therapies or, alone or in combination with other lipid-lowering therapies in patients who are statin-intolerant or for whom statin is contraindicated to reduce cardiovascular risk by lowering LDL-C levels. **Dosage:** Primary hypercholesterolaemia or mixed dyslipidaemia: Recommended dose 140 mg every 2 weeks or 420 mg once monthly; both doses are clinically equivalent. Homozygous familial hypercholesterolaemia: Initial recommended dose 420 mg once monthly. After 12 weeks, can be up titrated to 420 mg once every 2 weeks if clinically meaningful response is not achieved. Patients on apheresis may initiate treatment with 420 mg every 2 weeks to correspond with their schedule. Established atherosclerotic cardiovascular disease: Recommended dose 140 mg every two weeks or 420 mg once monthly; both doses are clinically equivalent. No dose adjustment is necessary in elderly patients (age ≥65 years), patients with renal impairment or with mild hepatic impairment. **Method of use:** S/c injection into the abdomen, thigh or upper arm region. Sites should be rotated and injections should not be given where skin is tender, bruised, red, or hard. Must not be administered i/v or i/m. The 420 mg dose should be administered consecutively using 3 pre-filled autoinjectors within 30 mins. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Precautions:** Patients with moderate hepatic impairment: A reduction in total evolocumab exposure observed may lead to a reduced effect on LDL C reduction; close monitoring may be warranted. Used with caution in patients with severe hepatic impairment. Needle cover of pre-filled autoinjector is made from dry natural rubber (a derivative of latex), which may cause severe allergic reactions. **Interactions:** ~20% increase in the clearance of evolocumab was observed in patients co-administered statins. No statin dose adjustments are necessary when used in combination with evolocumab. **Pregnancy:** Should not be used during pregnancy unless the clinical condition of the woman requires treatment with evolocumab. **Side effects:** Common: Influenza, nasopharyngitis, upper respiratory tract infection, hypersensitivity, rash, nausea; back pain, arthralgia; injection site reactions such as bruising, erythema, haemorrhage, pain, swelling.

Please read the full prescribing information prior to administration and full prescribing information is available upon request. HKREPPI04

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References: 1. Sabatine MS, et al. *N Engl J Med* 2017;376:1713–1722. 2. Koren MJ, et al. *J Am Coll Cardiol* 2019;74:2132–2146. 3. Amgen. Data on file.
4. Amgen. Amgen Announces Positive Results At ACC.20/WCC From Phase 3B Study Of Repatha® (Evolocumab) In People Living With HIV Who Have High LDL-Cholesterol [press release]. Available at: https://www.amgen.com/media/news-releases/2020/03/amgen-announces-positive-results-at-acc20wcc-from-phase-3b-study-of-repatha- evolocumab-in- people-living-with-hiv-who- have-high- ldlcholesterol/. Accessed 03 September 2020.

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MO-00317-REP-2022-Sep
Date of approval: Oct 2022

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90mg

Improved outcomes matter

BRILINTA® ticagrelor tablets

Reduction in CV events1†

-16%

p<0.001

Reduction in CV death1

-21%

p=0.001

Reduction in MI1

-16%

p=0.005

2020 ESC Guideline recommendations for antithrombotic treatment in NSTE-ACS patients without atrial fibrillation undergoing PCI2

Recommendations	Class	Level
A P2Y12 receptor inhibitor is recommended in addition to aspirin and maintained over 12 months unless there are contraindications or an excessive risk of bleeding. Options are:	I	A
BRILINTA™ irrespective of the planned treatment strategy (invasive or conservative) (180 mg LD, 90 mg b.i.d.)‡.	I	B

In 2021 ESC guidelines on cardiovascular disease prevention, prasugrel or BRILINTA™ is preferred as standard antithrombotic treatment after ACS for 12 months as DAPT4.

2016 ACC/AHA Guideline focused update on duration of dual antiplatelet therapy in patient with coronary artery disease3

Recommendations	Class	Level
In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after coronary stent implantation and in patients with NSTE-ACS treated with medical therapy alone (without revascularization), it is reasonable to use BRILINTA™ in preference to clopidogrel for maintenance P2Y12 inhibitor therapy.	IIa	B-R
In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after BMS or DES implantation, P2Y12 inhibitor therapy (clopidogrel, prasugrel, or BRILINTA™) should be given for at least 12 months.	I	B-R
In patients with ACS who are managed with medical therapy alone (without revascularization or fibrinolytic therapy) and treated with DAPT, P2Y12 inhibitor therapy (clopidogrel or BRILINTA™) should be continued for at least 12 months.	I	B-R

* The PLATO study was a multicentre, randomized, double-blind trial. 18,624 patients admitted to the hospital with an ACS, with or without ST-segment elevation were randomized to receive either BRILINTATM (180 mg loading dose, 90 mg twice daily thereafter) or clopidogrel (300 to 600 mg loading dose, 75 mg daily thereafter) for the prevention of cardiovascular events for 12 months. All patients receive aspirin at a dose of 75 to 100 mg/day unless they could not tolerate the drug. The primary efficacy variable was the time to the first occurrence of composite of death from vascular causes, myocardial infarction, or stroke. The principal secondary efficacy end point was the primary efficacy variable studied in the subgroup of patients for whom invasive management was planned at randomization1.

† CV events=CV death, MI, or stroke.

‡ Other options include prasugrel and clopidogrel.

ACC=American College of Cardiology. ACS=acute coronary syndrome. AHA=American Heart Association. BMS=bare metal stent. CAD=coronary artery disease. CV=cardiovascular. DAPT=dual antiplatelet therapy. DES=drug-eluting stent. EACTS=European Association for Cardio-Thoracic Surgery. EASD=European Association for the Study of Diabetes. ESC=European Society of Cardiology. MI=myocardial infarction. NSTE-ACS=non-ST elevation-acute coronary syndrome. PCI=percutaneous coronary intervention. STEMI=ST-segment elevation myocardial infarction.

References: 1. Wallentin L, et al. N Engl J Med. 2009; 361:1045-1057. 2. Collet JP, et al. Eur Heart J. 2021;42:1289-1367. 3. Levine GN, et al. Journal of the American College of Cardiology. 2016;68(10):1082-1115. 4. Visseren FLJ, et al. European Heart Journal. 2021;42(34):3227-3337.

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Presentation: Ticagrelor 90mg / 60mg film-coated tablet. Indication: Co-administered with aspirin, for prevention of atherothrombotic events in adult patients with ACS; or a history of myocardial infarction (MI) and a high risk of developing an atherothrombotic event. Dosage: Should be taken with 75-150mg aspirin daily, unless specifically contraindicated. For ACS patients, initiated with a single 180mg loading dose and then continued at 90mg twice daily for 12 months unless discontinuation is clinically indicated. For patients with a history of MI of at least one year and a high risk of an atherothrombotic event, when extended treatment is required, 60mg twice daily recommended. Contraindications: Hypersensitivity to any ingredients of this product; Active pathological bleeding; History of intracranial haemorrhage; Severe hepatic impairment; Co-administration with strong CYP3A4 inhibitors e.g. ketoconazole, clarithromycin, nefazodone, ritonavir, and atazanavir. Precautions and Interactions: Children <18 years; Pregnancy and lactation. Patients with a propensity to bleed; Concomitant use of medicinal products that may increase the risk of bleeding within 24 hours of dosing or known to alter haemostasis e.g. antifibrinolytic therapy and/or recombinant factor VIIa; Stop for 7-day before surgery; Moderate hepatic impairment; Patients at risk for bradycardic events; Concomitant use of medicinal products known to induce bradycardia; History of asthma and/or COPD; Patients ~75 years; Moderate/severe renal impairment; Concomitant treatment with an ARB; History of hyperuricaemia or gouty arthritis; Uric acid nephropathy; High aspirin maintenance dose (>300mg); Premature treatment discontinuation; Co-administration with potent CYP3A inducers e.g. rifampicin, phenytoin, carbamazepine and phenobarbital; Co-administration with CYP3A4 substrates with narrow therapeutic indices i.e. cisapride and ergot alkaloids; Patients on renal dialysis; Concomitant use of simvastatin or lovastatin ~40mg; Medicinal products metabolised by CYP3A4; CYP3A4 substrates with narrow therapeutic indices; Cyclosporine; SSRIs e.g. paroxetine, sertraline and citalopram. Undesirable effects: Blood disorder bleedings (bruise, spontaneous haematoma, haemorrhagic diathesis), hyperuricaemia, dyspnoea, gout/gouty arthritis, dizziness, syncope, headache, vertigo, hypotension, respiratory system bleedings (epistaxis, haemoptysis), gastrointestinal haemorrhage (gingival bleeding, rectal bleeding, gastric ulcer haemorrhage), diarrhea, nausea, dyspepsia, constipation, subcutaneous or dermal bleeding (ecchymosis, skin haemorrhage, petechiae), rash, pruritus, urinary tract bleeding (haematuria, cystitis haemorrhage), blood creatinine increased, post procedural haemorrhage, traumatic bleedings (contusion, traumatic haematoma, traumatic haemorrhage). Full local prescribing information is available upon request. API.HK.BRL90.0816 BRL60.0516

HK-6998 (27/04/2022)

Advancing the Management of Heart Failure with SGLT2i

Dr. TSANG Chun Fung, Sunny

Dr Sunny Tsang obtained his medical degree from the Chinese University of Hong Kong in 2007. He worked in the Queen Elizabeth Hospital as an Associate Consultant in Cardiology. He received the Hong Kong Heart Foundation scholarship in 2017 to further undergo training in Critical Care Cardiology and Advance Heart Failure in Cedars-Sinai Medical Center, Los Angeles California, USA. He is currently in private practice and he was the program leader in the Heart Failure Program and the Physician-in-Charge of the Cardiac Care Unit in the Queen Elizabeth Hospital. His special interests include cardiac intensive care and mechanical circulatory support device, advanced heart failure, and coronary intervention.

FORXIGA is now A CLASS 1A FIRST-LINE THERAPY for all HFrEF patients in ESC 2021 HF guideline[7,††]

SAVE LIFE
IN HFrEF

↓26% **Risk of CV death & Worsening of HF†**
(HR 0.74 [95% CI, 0.65,0.85]; p<0.001)

↓30% **Risk of Worsening of HF*,†**
(HR 0.70 [95% CI, 0.59, 0.83])

↓18% **Risk of CV Mortality***
(HR 0.82 [95% CI, 0.69, 0.98])

↓17% **All-cause Mortality‡,***
(HR 0.83 [95% CI, 0.71, 0.97])

Consistent Efficacy§ Regardless of¶

- With or without T2DM[2]
- Baseline eGFR[3,**]
- HF background therapy[4]
- LVEF status[6]

Simple and well tolerated[1,5]

- Comparable rate of volume depletion, renal dysfunction, and hypoglycemia vs placebo[1]
- 10 mg once daily[5]
- No dose titration[1,‡‡]
- Initiate treatment if GFR ≥25 mL/min

*Exploratory endpoint
†An episode of worsening heart failure was either an unplanned hospitalization or an urgent visit resulting in intravenous therapy for heart failure[1]
‡Due to the hierarchical testing strategy, all-cause mortality was nominally significant
§Primary endpoint (CV death or worsening of HF)
¶Post hoc analysis
**Baseline eGFR categories: <60 mL/min/1.73m² and ≥60 mL/min/1.73m²
††In 2021 ESC Guidelines for the treatment of HFrEF, dapagliflozin or empagliflozin are recommended for patients with HFrEF to reduce the risk of HF hospitalization and death (class I, level A).
‡‡In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. If well tolerated, the dose may be increased to 10 mg.

CI=confidence interval. CV=cardiovascular. GFR=glomerular filtration rate. HFrEF=HF with reduced ejection fraction. HR=hazard ratio. LVEF=Left ventricular ejection fraction. SGLT2=sodium-glucose co-transporter-2 inhibitor. SoC=standard of care. T2DM=type 2 diabetes.

References: 1. McMurray JJV et al. N Engl J Med 2019;381:1995–2008. 2. Petrie MC et al. JAMA 2020;323:1353–1368. 3. Jhund PS, et al. Circulation. 2021;143:298-309. 4. Docherty K, et al. Eur Heart J 2020;41:2379–92. 5. Forxiga Hong Kong Prescribing Information. 6. Dewan P, et al. European Journal of Heart Failure 2020;22(7):1247-1258. 7. McDonagh TA, et al. European Heart Journal 2021;00:1-128.

Abbreviated Prescribing Information (API)
FORXIGA (dapagliflozin)
Composition: Dapagliflozin propanediol monohydrate film coated tablet, 5 mg or 10 mg. **Therapeutic Indications:** For the treatment of insufficiently controlled type 2 diabetes mellitus in adults as an adjunct to diet and exercise, either as monotherapy when metformin is considered inappropriate due to intolerance, or in addition to other medicinal products for the treatment of type 2 diabetes. For the treatment of symptomatic chronic heart failure with reduced ejection fraction. For the treatment of chronic kidney disease. **Dosage and Administration:** Type 2 diabetes mellitus: Recommended dose is 10 mg to be taken orally once daily at any time of day with or without food. Tablets are to be swallowed whole. Heart Failure: Recommended dose is 10 mg to be taken orally once daily. Chronic Kidney Disease: Recommended dose is 10mg to be taken orally once daily. In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. **Contraindications:** Hypersensitivity to the active substance or to any of its excipients. **Warnings and Precautions:** Renal function, risk of volume depletion and/or hypotension should be taken into account in patients. Dosage of insulin and sulphonylurea (SU) may need to be readjusted to reduce the risk of hypoglycaemia. May add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. Use with caution in patients with increased risk of diabetic ketoacidosis; on anti-hypertensive therapy with a history of hypotension; elderly (≥ 65 years). Treatment should be temporarily interrupted when volume depleted; when treating pyelonephritis or urosepsis; in patients who are hospitalized for major surgical procedures or acute serious medical illnesses, until ketone values are normal. Should not be initiated in patients with type 1 diabetes; hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption. Additional glucose lowering treatment should be considered for glycaemic control improvementIf GFR is persistently below 45 ml/min for the treatment of diabetes; no dose adjustment is required based on renal function for the treatment of heart failure and chronic kidney disease. Due to limited experience, it is not recommended to initiate treatment with dapagliflozin in patients with GFR < 25 mL/min. Discontinue if suspected or diagnosed diabetic ketoacidosis; if Fournier's gangrene is suspected; when pregnancy is detected; while breast-feeding. Limited or no data in cardiac failure NYHA class IV; pregnancy; and paediatric population. **Adverse Reactions:** Very common: hypoglycaemia when used with SU or insulin. Common: vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, dyslipidaemia, decreased creatinine renal clearance (during initial treatment), and increased haematocrit. Uncommon: Fungal infection, volume depletion, thirst, constipation, dry mouth, nocturia, vulvovaginal and genital pruritus, increased blood creatinine (during initial treatment), increased blood urea, and decreased weight. Rare: diabetic ketoacidosis (when used in type 2 diabetes). Very rare: necrotising fasciitis of the perineum (Fournier's gangrene), angioedema. Not known: acute kidney injury. **Drug interaction:** Coadministration with rifampicin may reduce dapagliflozin systemic exposure; coadministration with mefenamic acid may increase dapagliflozin systemic exposure. Monitoring glycaemic control with 1,5-AG assay is not recommended in patients taking SGLT2 inhibitors. **Storage:** Store below 30 °C. **Local prescribing information is available upon request. API.HKFOR.1221**

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Bring Protection to Life

forxiga® (dapagliflozin)

HK-6755 3/3/2022 4iC_1741

RIVA-DM : New Real-world Findings Confirm the Efficacy and Safety of Xarelto® in Patients with NVAF and Diabetes[1-3]

REDUCED RISKS WITH XARELTO® vs WARFARIN

Composite Outcome[1]

↓9%

SSE/CV death

Diabetes-related Complications

↓19%

Need for dialysis or renal transplant[2]

↓15%

MALE[2]

↓15%

Any type of diabetic retinopathy[3]

Bleeding Events[1]

↓20%

Major bleeding

↓28%

ICH

RIVA-DM study was a cohort analysis within the US Optum® De-Identified EHR dataset between 2010 to 2019. It included patients with NVAF and diabetes: 32,078 patients on Xarelto® and 83,971 patients on warfarin. Patients had follow-up data for an average of 2.9 years. The primary efficacy and safety outcomes were incidence rates of developing the composite of SSE/vascular death or major/CRNM bleeding resulting in hospitalization.

CRNM=clinically relevant non-major; CV=cardiovascular; ICH=intracranial hemorrhage; MALE=major adverse limb events; NVAF=non-valvular atrial fibrillation; SSE=stroke/systemic embolism.

References: 1. Coleman CI, et al. Thromboembolism, bleeding and vascular death in nonvalvular atrial fibrillation patients with type 2 diabetes receiving rivaroxaban or warfarin. Cardiovasc Diabetol 2021;20:52. **2.** Costa OS, et al. Kidney, limb and ophthalmic complications and death in patients with nonvalvular atrial fibrillation and type 2 diabetes prescribed rivaroxaban or warfarin: an electronic health record analysis. EHRA Congress. 23–25 April 2021. **3.** Costa OS, et al. Ophthalmic complications in patients with nonvalvular atrial fibrillation and type 2 diabetes prescribed rivaroxaban or warfarin. EHRA Congress. 23–25 April 2021.

Xarelto 10 mg / 15 mg / 20 mg film-coated tablets
Abbreviated Prescribing Information (Please refer to the full prescribing information before prescribing)
Composition: Active ingredient: 10 mg / 15 mg / 20 mg rivaroxaban. Excipients: Microcrystalline cellulose, croscarmellose sodium, lactose monohydrate, hypromellose, sodium laurilsulfate, magnesium stearate, macrogol 3350, titanium dioxide (E171), iron oxide red (E172). **Indication and Posology:** Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack: Recommended dose is 20 mg once daily (recommended maximum dose). Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and prevention of recurrent DVT and PE in adults: The recommended dose for the initial treatment of acute DVT or PE is 15 mg twice daily for the first three weeks followed by 20 mg once daily for the continued treatment and prevention of recurrent DVT and PE. When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg once daily. A dose of 20 mg once daily should be considered in patients with high risk. Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery: The recommended dose is 10 mg once daily. The initial dose should be taken 6 to 10 hours after surgery, provided that haemostasis has been established. For patients undergoing major hip surgery, a treatment duration of 5 weeks is recommended. For patients undergoing major knee surgery, a treatment duration of 2 weeks is recommended. **Patients with NVAF who undergo percutaneous coronary intervention (PCI) with stent placement:** There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [creatinine clearance 30 – 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement. **Renal impairment:** No dose adjustment is necessary in patients with mild renal impairment (creatinine clearance 50 - 80 ml/min). In patients with moderate (creatinine clearance 30 - 49 ml/min) or severe (creatinine clearance 15 - 29 ml/min) renal impairment the following dosage recommendations apply: For the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation, the recommended dose is 15 mg once daily. For the treatment of DVT,treatment of PE and prevention of recurrent DVT and PE: 15 mg twice daily for the first 3 weeks. Thereafter, the recommended dose is 20 mg once daily. When the recommended dose is 10 mg once daily, no dose adjustment from the recommended dose is necessary. Limited clinical data for patients with severe renal impairment (creatinine clearance 15 - 29 ml/min) indicate that rivaroxaban plasma concentrations are significantly increased; therefore, Xarelto is to be used with caution in these patients. Use is not recommended in patients with creatinine clearance < 15 ml/min. **Contraindications:** Hypersensitivity to the active substance or any of the excipients; active clinically significant bleeding; lesion or condition if considered a significant risk for major bleeding; concomitant treatment with any other anticoagulants except under specific circumstances of switching anticoagulant therapy or when unfractionated heparin is given at doses necessary to maintain an open central venous or arterial catheter; hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C; pregnancy and breast feeding. **Warnings and Precautions:** Clinical surveillance in line with anticoagulation practice is recommended throughout the treatment period. Not recommended: in patients receiving concomitant systemic treatment with strong concurrent CYP3A4- and P-gp-inhibitors, i.e. azole antimycotics or HIV protease inhibitors; in patients with increased bleeding risk; in patients with severe renal impairment (creatinine clearance < 15 ml/min); in the treatment of acute pulmonary embolism; due to lack of data: in patients below 18 years of age, in patients with prosthetic heart valves, in patients concomitantly treated with dronedarone, in NVAF-PCI patients with a history of stroke/transient ischemic attack. Use with caution: please refer to the full prescribing information. Xarelto contains lactose. **Undesirable effects:** Common: anaemia, dizziness, headache, eye haemorrhage, hypotension, haematoma, epistaxis, haemoptysis, gingival bleeding, gastrointestinal tract haemorrhage, gastrointestinal and abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting, pruritus, rash, ecchymosis, cutaneous and subcutaneous haemorrhage, pain in extremity, urogenital tract haemorrhage, fever, renal impairment, peripheral oedema, decreased general strength and energy, increase in transaminases, post-procedural haemorrhage, contusion, wound secretion. Other undesirable effects (uncommon, rare, frequency not known): please refer to the full prescribing information.

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Xarelto rivaroxaban

Management of Heart Failure Hospitalisation:Role of SGLT2 inhibitors and Practical Consideration

Prof.TSE Hung Fat

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MBBS(HK), MD(HK), PhD(HK), MRCP(UK), FRCP(Edinburgh, Glasgow, Lond), FHKCP, FHKAM(Medicine)

ABSTRACT

Heart failure is a progressive, devastating disease affecting 60 million people worldwide, and expected to increase as the population ages. There is currently a high unmet need in the treatment of heart failure, as approximately half of all those diagnosed are expected to die within five years. The sodium–glucose cotransporter 2 (SGLT2) inhibitors empagliflozin and dapagliflozin significantly reduce the risk of cardiovascular death or hospitalization for heart failure in patients with chronic heart failure with a reduced left ventricular ejection fraction (LVEF) and a preserved LVEF. Empagliflozin additionally provided evidence for in-hospital initiation of empagliflozin in patients with acute heart failure following stabilization in the EMPULSE study. Clinical benefit was observed for both acute de novo and decompensated chronic heart failure and was observed regardless of ejection fraction or the presence or absence of diabetes. In this lecture, clinical evidence and practical consideration on the use of SGLT2 inhibitors in this setting will be discussed.

Management of Heart Failure Hospitalisation:Role of SGLT2 inhibitors and Practical Consideration

Prof.TSE Hung Fat

BIOGRAPHY

Professor Hung-Fat Tse is Chairperson of the Department of Medicine, School of Clinical Medicine, Li Ka Shing Faculty of Medicine, the University of Hong Kong. He is also Chief of the Cardiology Division, Honorary Consultant and Chief of Service of the Department of Medicine at Queen Mary Hospital.

Professor Tse received his medical degree from the University of Hong Kong, Hong Kong. He completed his postgraduate training in Internal Medicine and Cardiology in the Department of Medicine, Queen Mary Hospital, University of Hong Kong, and his cardiac-electrophysiology training fellowship at the University of Michigan, USA.

Professor Tse is an international expert in cardiac pacing and electrophysiology, and cardiovascular regenerative medicine. He has significantly contributed to the understanding of the mechanisms as well as development of novel therapies for treatment of heart rhythm disorder. In addition, Professor Tse is at the forefront of applying stem cells in cardiovascular regenerative medicine. His research center and basic laboratory together with the Sun Chieh Yeh Cardiovascular Research and Training Laboratory (for large animal research) are dedicated to the training and development of novel device and biological therapies for cardiovascular diseases. Prof. Tse has published over 520 original scientific reports in international scientific journals, including New England Journal of Medicine, Nature Medicine, Lancet, Cell Stem Cell, Circulation, Blood, Journal of American College of Cardiology, Archives of Internal Medicine, American Journal of Medicine, European Heart Journal and Stem Cell.

Professor Tse's current projects include:

Basic and clinical cardiac electrophysiology;

Novel non-pharmacological therapies, such as medical devices and gene-based approaches for cardiac arrhythmias;

Non-invasive assessment of cardiovascular system, such as vascular ultrasound, CT scan and MRI; and

Cardiovascular regenerative medicine using gene-based and cell-based, including adult, embryonic and induced pluripotent stem cells.

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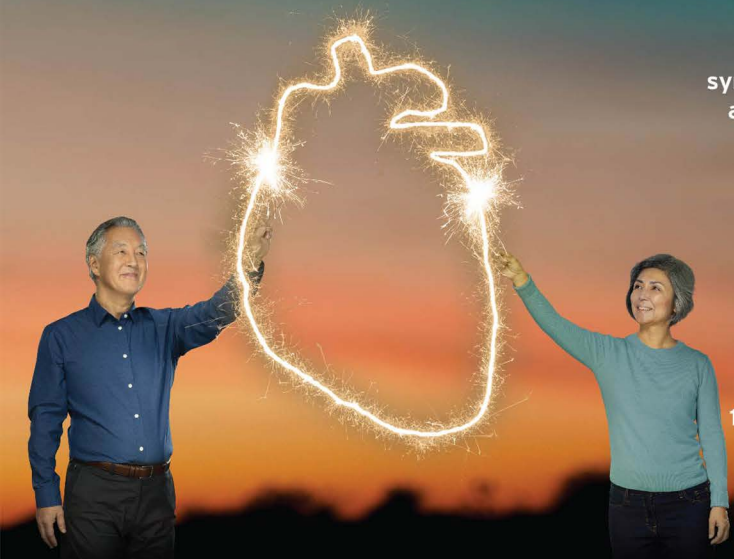

Approved* to reduce the risk of CV death or HHF in symptomatic chronic heart failure across the LVEF spectrum‡§¶-3

25% RRR
LVEF ≤ 40%^2

21% RRR
LVEF > 40%‖1

Established safety and tolerability profile¶-3

Simple dosing: oral, 10 mg once daily, no titration#3

Recognizing EMPEROR-Reduced and EMPEROR-Preserved trial JARDIANCE is recommended across the LVEF spectrum4**

Jardiance® (empagliflozin)

* Approved = Jardiance 10mg is indicated in adults for the treatment of symptomatic chronic heart failure in Macau

‡ Adult patients with chronic heart failure (NYHA class II, III, or IV) and reduced ejection fraction (LVEF ≤ 40%). Adult patients with chronic heart failure (NYHA class II, III, or IV) and preserved ejection fraction (LVEF > 40%).[1,2]

§ In the EMPEROR-Preserved trial, a randomised, double-blind, parallel-group, placebo-controlled study of 5988 patients with HFpEF, the efficacy and safety of JARDIANCE 10 mg (n=2997) were evaluated vs placebo (n=2991). The primary endpoint in the EMPEROR-Preserved trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 21% RRR in this endpoint (HR=0.79; 95% CI: 0.69, 0.90; p<0.001). In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[1,2]

^ In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary composite endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[2]

‖ In the EMPEROR-Preserved trial, a randomised, double-blind, parallel-group, placebo-controlled study of 5988 patients with HFpEF, the efficacy and safety of JARDIANCE 10 mg (n=2997) were evaluated vs placebo (n=2991). The primary composite endpoint in the EMPEROR-Preserved trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 21% RRR in this endpoint (HR=0.79; 95% CI: 0.69, 0.90; p<0.001).[1]

¶ When Jardiance is used in combination with a sulphonylurea or with insulin, a lower dose of the sulphonylurea or insulin may be considered to reduce risk of hypoglycaemia.[3]

** The SGLT2i class, such as Jardiance, has gained a 1A recommendation for HFrEF and a 2a-B-R recommendation for HFmrEF and HFpEF.[4]

CI=confidence interval; CV=cardiovascular; HFpEF=heart failure with preserved ejection fraction; HFrEF=heart failure with reduced ejection fraction; HFmrEF=heart failure with mid range ejection fraction; HHF=hospitalisation for heart failure; HR=hazard ratio; LVEF=left ventricular ejection fraction; NYHA=New York Heart Association; RRR=relative risk reduction; SGLT2i=sodium-glucose cotransporter 2 inhibitor

JARDIANCE® Abbreviated Prescribing Information (aPI-JARD-02)

Presentation: Empagliflozin. Film-coated tablets 10 mg; 25 mg. **Indications: 10 mg and 25 mg:** Indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as: monotherapy when diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance; and as add-on combination therapy with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control. Indicated in patients with type 2 diabetes mellitus and established cardiovascular disease to reduce the risk of cardiovascular death. **10 mg:** Jardiance is indicated in adults for the treatment of symptomatic chronic heart failure. **Dosage and administration: Type 2 diabetes mellitus:** 10 mg once daily. In patients tolerating 10 mg once daily and requiring additional glycaemic control, the dose can be increased to 25 mg once daily. Can be taken with or without food. No dose adjustment is required for patients with eGFR ≥ 30 mL/min/1.73m² or with hepatic impairment, or for elderly patients. **Heart Failure:** 10 mg once daily. Can be taken with or without food. In HF patients with or without T2DM, 10 mg may be initiated or continued down to an eGFR of 20 ml/min/1.73m² or CrCl of 20 ml/min. **Contraindication:** Hypersensitivity to empagliflozin or any of the excipients. For the treatment of Type 2 diabetes, JARDIANCE should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis, as glycaemic efficacy depends on renal function. **Special warnings and precautions:** Should not be used in patients with type 1 diabetes or for treatment of ketoacidosis. Discontinue immediately when ketoacidosis is suspected or diagnosed. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses, and may be restarted once the patient's condition has stabilised. For type 2 diabetes mellitus, should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis. For HF, not recommended for use when eGFR < 20 mL/min/1.73m². Discontinue in cases of recurrent UTI. Due to a risk of modest decrease in blood pressure, caution should be exercised in patients with known cardiovascular disease, patients on diuretics, patients with history of hypotension or patients aged 75 years and older. Monitoring of volume status and electrolytes is recommended. Regularly examine the feet and counsel patients on routine preventative footcare. Caution is advised in patients at increased risk of genital infections. Avoid use during pregnancy and breast-feeding. Safety and effectiveness in children under 18 years of age have not been established. Initiation is not recommended in patients aged 85 years and older. Urine will test positive for glucose while patients are taking JARDIANCE. **Interactions:** Risk of dehydration and hypotension may increase when used in combination with thiazide and loop diuretics. Lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with JARDIANCE. **Adverse reactions:** Hypoglycaemia (depends on type of background therapy of patients); Urinary tract infection, vaginal moniliasis, vulvovaginitis, balanitis and other genital infection; Increased urination, dysuria; Pruritus; Volume depletion; Thirst; Glomerular filtration rate decreased, blood creatinine increased, haematocrit increased, serum lipids increased. Post-marketing experience: Ketoacidosis, complicated urinary tract infections, necrotising fasciitis of the perineum (Fournier's gangrene), allergic skin reaction, angioedema. **Storage condition:** Please refer to outer packaging for special precautions for storage. **Note:** Before prescribing, please consult full prescribing information.

References: 1. Anker SD, Butler J, Filippatos G, et al; EMPEROR-Preserved Trial Investigators. Empagliflozin in heart failure with a preserved ejection fraction. N Engl J Med. 2021;385(16):1451-1461. (EMPEROR-Preserved results and the publication's Supplementary Appendix.) **2.** Packer M, Anker SD, Butler J, et al; EMPEROR-Reduced Trial Investigators. Cardiovascular and renal outcomes with empagliflozin in heart failure. N Engl J Med. 2020;383(15):1413-1424. (EMPEROR-Reduced results and the publication's Supplementary Appendix.) **3.** Jardiance Hong Kong Prescribing Information. **4.** Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA guideline for the management of heart failure: executive summary: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines [Epub ahead of print]. J Am Coll Cardiol. 2022. doi:10.1016/j.jacc.2021.12.011

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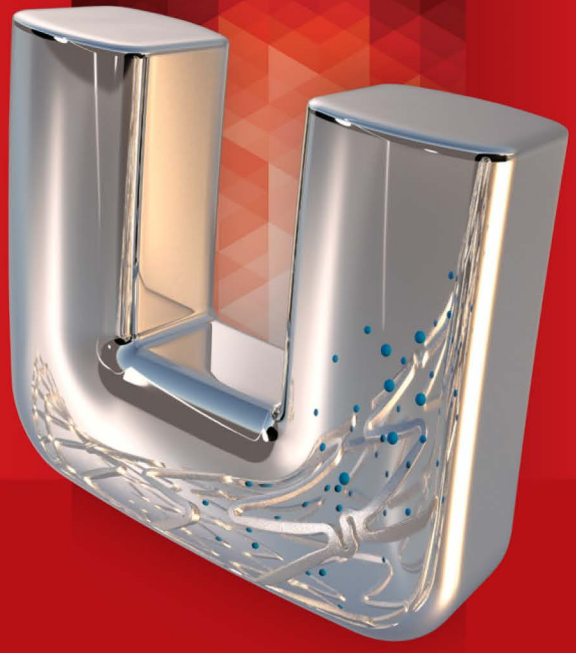

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Medical assessor and subcommittee member, the Hong Kong Medical Council
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In coronary intervention, Dr Lam had won many best case awards all around the world.
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Innovative Approach to Cholesterol Control

Prof.YIU Kai Hang

Clinical Professor
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Honorary Consultant, Hong Kong Sanatorium Hospital
Division Chief, Cardiology Division, University of Hong Kong-ShenzhenHospital
Assistant Hospital Chief Executive, University of Hong Kong-ShenzhenHospital

BIOGRAPHY

Prof. Yiu received his Bachelor (2001) and Doctor (2012) of Medicine degrees from the University of Hong Kong. He joined the University of Hong Kong (HKU) in 2011 as a Clinical Assistant Professor in Cardiology, promoted to Clinical Associate Professor in 2015 and Clinical Professor in 2022. He has completed his PhD in 2016 at the Leiden University, the Netherlands on "Clinical application of cardiac imaging: echocardiography and computed tomography". He has prolifically published over 190 peer-review original articles in international peer-review journals. Among these, he was either first or corresponding author in 70 of them; including over 40 articles with impact factors exceeding 5 (Maximum 30). In addition, Prof. Yiu was one of the first in Asia (2010, Lepzig Germany) to perform transcatheter aortic valvular implantation (TAVI) and had performed over 40 procedures during his overseas training.

Innovative Approach to Cholesterol Control

Prof.YIU Kai Hang

Prof. Yiu's research interest is based on Advanced Cardiovascular imaging and Big data analytics. By using various cardiovascular imaging techniques, he was able to identify subclinical cardiovascular abnormalities that improves management of patients with or at risk of cardiovascular disease. Furthermore, he has established and led three important research study projects, namely the Chinese Valvular Heart Disease study (CVATS), the Chinese Diabetic Heart Disease Study (CDATS) and the Chinese Rheumatology Heart Disease Study (CRADS). Using big data analytics, Prof. Yiu was able to evaluate epidemiology in common cardiovascular diseases as well as drug safety and efficacy. Prof.Yiu receives several key external competitive grants, including 3 GRF grants, 1 HMRF grant,ITF-midstream grant etc.. with a total of over 25 million HKD.

Prof. Yiu's clinical interest includes interventional cardiology (coronary and structural) and advanced cardiac imaging (both invasive and non-invasive). He is also leading the cardiology service in the HKUSZ hospital and currently the deputy director of the Cardiac and Vascular centre, HKUSZ hospital. Under his leadership, the cardiology division was awarded the Key Development Specialty Award by the Shenzhen Municipal Health Commission in 2020 – 重點培育學科. He is the recipient of the 23 Australian Council on Healthcare Standards Quality Improvement Global Award, the only institute in Asia to be so recognised.

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

-34%
in chronic heart failure 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. Maximum recommended dose for CHF is 10mg bisoprolol fumarate once daily. Special populations: In severe renal impairment (creatinine clearance <20ml/min) or severe liver function disorders a daily dose of 10mg bisoprolol fumarate should not be exceeded for treatment of hypertension of angina pectoris and dose titration in patients with these functional impairments for CHF should be made with particular caution. Use in children is not recommended. Treatment with bisoprolol must not be stopped abruptly, since this might lead to a transitory worsening of heart condition. If transient worsening of heart failure, hypotension or bradycardia occurs during or thereafter the titration phrase, recommend to reconsider the dosage of concomitant medication, or temporarily lower the dose of bisoprolol, or discontinuation. Reintroduction and/or, up titration of bisoprolol should always be considered when patient becomes stable again. 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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11/F, Elite Centre, 22 Hung To Road, Kwun Tong, Kowloon, Hong Kong Tel.: +(852) 2170 7700 Fax: +(852) 2345 2040

HK-MULCMC-00028 JUL2022

What is the best Angina Management

Dr.TAM Weng Chio

Membership:
2017—Macau Cardiology Association
2016 --Taiwan society of critical care medicine
2015—Taiwan society of cardiovascular intervention
2012-- Taiwan Society of Cardiology
2010-- Taiwan Society of Internal Medicine

ABSTRACT

Angina, being one of the commonest symptoms of heart diseases, is often under-diagnosed and under-managed. Approximately, half of the patients still experience angina after discharge from acute coronary syndrome. As angina is multi-factorial, the causes involve different mechanisms, and ischemia with nonobstructive coronary arteries (INOCA) is often underestimated. This lecture will investigate the underlying causes of angina and its burden, how angina affect one' s quality of life. Also, it will share the latest evidence and evolution of guidelines for angina management. Traditionally, angina is managed through a step-wise approach. However, like other diseases, it is now understood that personalized management can achieve an optimal outcome for patients, and this lecture will discuss the importance and benefits for a personalized approach for patients.

What is the best Angina Management

Dr.TAM Weng Chio

本人譚永超(Tam Weng Chio)，於中國台灣台北醫學大學就讀醫學系，畢業後曾於台北市立萬芳醫院，長庚醫院接受內科及心臟科訓練，完成心臟內科專科完整訓練後，並於2014年正式成為心臟科主治醫師，於2017年獲中國澳門特別行政局衛生局認證心臟科專科資格，同時成為澳門仁伯爵綜合醫院的心臟科主治醫師，工作期間曾於國際期刊中發表多篇國際論文，目前也是澳門心臟學會理監事，也是台灣心臟學會及心臟介入學會，重症醫學會及內科學會會員，主要研究方向為心臟起搏器介入和冠脈介入治療，曾於社會基層醫療服務和國際會議中獲得獎項。

Office:
Department of Cardiology, Centro Hospitalar Conde São Januário, Macau SAR

Education:
2002-2009 Taipei medical university, Taiwan

Current Position:
2017-2022 A.H. Cardiologist, Department of Cardiology, Centro Hospitalar Conde São Januário, Macau SAR

Professional Experience:

2009-2012 Resident Physician, Department of Internal Medicine, Taipei Medical University-Wan Fang Hospital
2012-2014 Fellow in Cardiology, Department of Internal Medicine, Taipei Medical University-Wan Fang Hospital
2014-2017 Physician of Cardiology, Department of Internal Medicine, Taipei Medical University-Wan Fang Hospital
2014-2017 Physician of critical care medicine, Department of critical care unit, Taipei Medical University-Wan Fang Hospital
2015-2017 Pacemaker clinical Training, Department of cardiology, Linkou Chang Gung Memorial Hospital
2017-2023 A.H. Cardiologist, Department of Cardiology, Centro Hospitalar Conde São Januário, Macao SAR

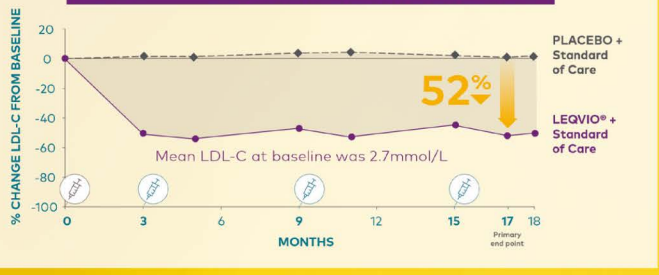
LEQVIO®
(inclisiran) injection 284 mg/1.5 mL

2 DOSES A YEAR*
FOR EFFECTIVE AND SUSTAINED LDL-C REDUCTION[1†]

FDA APPROVED[2]

EMA APPROVED[3]

In ORION-10 (N=1,561), LEQVIO® demonstrated LDL-C reduction in patients with established **ASCVD**[1,4]



Patients in both study arms were on a maximally tolerated statin.[1,4]

In ORION-10 clinical trial, LEQVIO® demonstrated LDL-C reduction in ASCVD patients:[4]

52% EFFECTIVE LDL-C REDUCTION

Between-group difference of -52.3% (95% CI: -55.7%, -48.8%; P<0.001) refers to the difference between the placebo group (1.0%) and the LEQVIO® group (-51.3%) at month 17.

*LEQVIO® is dosed initially, again at 3 months, and then once every 6 months.[1]
†LDL-C reduction was maintained during each 6-month dosing interval.[1]

Study design: ORION-10 was a multicenter, double-blind, randomized, placebo-controlled 18-month clinical trials. Patients with established ASCVD were taking a maximally tolerated dose of statin with or without other lipid-modifying therapy and required additional LDL-C reduction. The ORION-11 trial, in addition to patients with ASCVD, included adults who were ASCVD risk equivalent (type 2 diabetes, familial hypercholesterolemia, or a 10-year risk of a cardiovascular event of >20% as assessed by the Framingham Risk Score for Cardiovascular Disease or equivalent).

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; CI, confidence interval; LDL-C, low-density lipoprotein cholesterol

References: 1. Leqvio. Hong Kong Prescribing Information. Novartis Pharmaceuticals. 2021. **2.** U.S. Food & Drug Administration. FDA approves add-on therapy to lower cholesterol among certain high-risk adults. https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-add-therapy-lower-cholesterol-among-certain-high-risk-adults. Published Dec 2021. Accessed on 12 Apr 2022. **3.** European Medicine Agency. https://www.ema.europa.eu/en/medicines/human/EPAR/leqvio. Accessed on 22 Mar 2022. **4.** Ray KK, Wright RS, Kallend D, et al; ORION-10 and ORION-11 Investigators. Two phase 3 trials of inclisiran in patients with elevated LDL cholesterol. N Engl J Med. 2020;382(16):1507-1519.

Leqvio® Important note: Before prescribing, consult full prescribing information. **Presentation: Solution for injection:** Each pre-filled syringe contains 1.5 mL of solution containing 284 mg inclisiran (equivalent to 300 mg inclisiran sodium). **Indications:** Leqvio is indicated in adults with primary hypercholesterolaemia (heterozygous familial and nonfamilial) or mixed dyslipidaemia, as an adjunct to diet: • in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDLC goals with the maximum tolerated dose of a statin, or • alone or in combination with other lipid lowering therapies in patients who are statin intolerant, or for whom a statin is contraindicated. **Dosage and administration:** *Recommended dose:* 284 mg inclisiran administered as a single subcutaneous injection: initially, again at 3 months, followed by every 6 months. *Missed dose:* • If a planned dose is missed by less than 3 months, inclisiran should be administered and dosing continued according to the patient's original schedule. • If a planned dose is missed by more than 3 months, a new dosing schedule should be started – inclisiran should be administered initially, again at 3 months, followed by every 6 months. *Treatment Transition from PCSK9 Inhibitor Monoclonal Antibody:* Inclisiran can be administered immediately after the last dose of a monoclonal antibody PCSK9 inhibitor. To maintain LDL C lowering it is recommended that inclisiran is administered within 2 weeks after the last dose of a monoclonal antibody PCSK9 inhibitor. **Special populations:** *Renal impairment:* No dose adjustments are necessary for patients with mild, moderate or severe renal impairment or patients with end stage renal disease. There is limited experience with inclisiran in patients with severe renal impairment. Inclisiran should be used with caution in these patients. *Hepatic impairment:* No dose adjustments are necessary for patients with mild (Child Pugh class A) or moderate (Child Pugh class B) hepatic impairment. No data are available in patients with severe hepatic impairment (Child Pugh class C). Inclisiran should be used with caution in patients with severe hepatic impairment. *Pediatric patients (below 18 years):* The safety and efficacy of inclisiran have not been established. *Geriatric patients (65 years of age or above):* No dose adjustment is necessary. **Method of administration:** Intended for administration by a healthcare professional. For subcutaneous injection into the abdomen, alternative injection sites include the upper arm or thigh. Injections should not be given into areas of active skin disease or injury such as sunburns, skin rashes, inflammation or skin infections. Leqvio should be inspected visually for particulate matter prior to administration. Each pre-filled syringe is for single use only. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** ***Haemodialysis:*** Considering that inclisiran is eliminated renally, haemodialysis should not be performed for at least 72 hours after inclisiran dosing. **Pregnancy, lactation, females and males of reproductive potential.** ***Pregnancy:*** There are no or limited amount of data from the use of inclisiran in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. As a precautionary measure, it is preferable to avoid the use of inclisiran during pregnancy. ***Lactation:*** It is unknown whether inclisiran is excreted in human milk. Available pharmacodynamic/toxicological data in animals have shown excretion of inclisiran in milk. A risk to newborns/infants cannot be excluded. A decision must be made whether to discontinue breast feeding or to discontinue/abstain from inclisiran therapy, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. ***Infertility:*** No human data. No effects on animal fertility. **Adverse drug reactions:** ***Common (≥1 to <10%):*** Adverse events at the injection site (includes injection site reaction, injection site pain, injection site erythema, and injection site rash). **Interactions:** Not a substrate, inhibitor or inducer of CYP450 enzymes or common drug transporters. Not expected to have clinically significant interactions with other medications. Drug–drug interaction assessments demonstrated a lack of clinically meaningful interactions with either atorvastatin, rosuvastatin or other statins. **Packs:** Solution in pre-filled syringe: 1's **Legal classification:** P1S153 Last revision: Sep 2021 Ref: EU Dec 2020

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Are Statin enough? When to consider PCSK9 inhibitors

Dr.WONG Chi Yuen

Dr Wong Chi Yuen, Eric graduated from the University of Hong Kong and received his internal medicine and cardiology training in Queen Elizabeth Hospital.

In 2010 he underwent 1 year overseas training in Mayo Clinic, Rochester in USA, specialized in Echocardiography.

Currently he is the Consultant of Queen Elizabeth Hospital, Director of Echocardiography Laboratory and in-charge of noninvasive cardiac investigation service. His interests include 3D Echocardiography, Interventional Echo during structural heart diseases interventions, management of pulmonary hypertension and hypertrophic cardiomyopathy.

He is the Council Member of Hong Kong College of Cardiology (HKCC) and member of Echo Chapter of HKCC.

Council Member
Hong Kong College of Cardiology
Sep 2019 - Present · 3 years 5 months

FASE
Nov 2021 - Present · 1 year 3 months
The American Society of Echocardiography

FRCP
Nov 2019 - Present · 3 years 3 months

Royal College of Physicians of Edinburgh
Honorary Clinical Associate Professor
Aug 2017 - Present · 5 years 6 months

香港中文大學
Honorary Clinical Assistant Professor
Aug 2013 - Present · 9 years 6 months
Hong Kong

The University of Hong Kong
Council Member

Hong Kong Public Hospital Cardiologist Association (HKPHCA)
Oct 2016 - Sep 2020 · 4 years
Hong Kong

Clinical Fellow
Jul 2010 - Jun 2011 · 1 year
Fellowship of Echocardiography


Philips Azurion,
a new-generation image guided therapy platform that transforms the interventional suite
With Azurion, performance and superior care become one
innovation + you

ELIQUIS™

THE SAFER CHOICE[1,2*]

#1 NOAC globally[3]

Choose both efficacy and safety with ELIQUIS™

- The ONLY NOAC to offer both **superior risk reduction in stroke/SE and major bleeding** over warfarin in NVAF[1,2*]
- **Continued efficacy, with favorable bleeding profile** regardless of bleeding endpoint, for the treatment of DVT/PE[4†]

* There are no head-to-head trials comparing NOACs

† ELIQUIS™ provided significant risk reduction across all types of bleeding vs enoxaparin/warfarin in patients treated for DVT/PE[4]

References: 1. Granger CB, et al. *N Engl J Med* 2011;365:981-992. **2.** Ruff CT, et al. *Lancet* 2014;383:955-962. **3.** IQVIA MIDAS, Days of Treatment volume a calculation of IQVIA Standard Units, Q2 2019, divided by recommended administration of each NOAC within 24hrs. [apixaban BID, dabigatran BID, edoxaban QD, rivaroxaban QD) **4.** Agnelli G, et al. *N Engl J Med* 2013;369:799-808.

ELIQUIS ABBREVIATED PACKAGE INSERT 1. TRADE NAME: ELIQUIS 2. PRESENTATION: 2.5 mg and 5 mg film-coated tablets **3. INDICATIONS:** Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors, such as prior stroke or transient ischaemic attack (TIA); age ≥ 75 years; hypertension; diabetes mellitus; symptomatic heart failure (NYHA Class ≥ II). Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults. For 2.5 mg only – Prevention of venous thromboembolic events (VTE) in adult patients who have undergone elective hip or knee replacement surgery. **4. DOSAGE:** Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation (NVAF): 5 mg twice daily. 2.5 mg twice daily in patients with NVAF and at least two of the following characteristics: age ≥ 80 years, body weight ≤ 60 kg, or serum creatinine ≥ 1.5 mg/dl (133 micromole/L). Treatment of DVT, PE and prevention of recurrent DVT and PE (VTE): 10 mg twice daily for the first 7 days followed by 5 mg twice daily. When prevention of recurrent DVT and PE is indicated, the 2.5 mg twice daily dose should be initiated following completion of 6 months of treatment with Eliquis 5 mg twice daily or with another anticoagulant. Prevention of VTE in elective hip or knee replacement surgery: 2.5 mg twice daily initiated 12 to 24 hours after surgery. **5. METHOD OF ADMINISTRATION:** Eliquis should be swallowed with water with or without food. For patients who are unable to swallow whole tablets, Eliquis tablets may be crushed and suspended in water or 5% dextrose in water (D5W) and immediately administered orally. Alternatively, Eliquis tablets may be crushed and suspended in 60mL of water or D5W and immediately delivered through a nasogastric tube. Crushed Eliquis tablets are stable in water and D5W for up to 4 hours. **6. CONTRAINDICATIONS:** Hypersensitivity to the active substance or to any of the excipients. Active clinically significant bleeding. Hepatic disease associated with coagulopathy and clinically relevant bleeding risk. Lesion or condition if considered a significant risk factor for major bleeding. Concomitant treatment with any other anticoagulant agent. **7. WARNINGS & PRECAUTIONS:** Haemorrhage risk: carefully observed for signs of bleeding. Eliquis should be discontinued if severe haemorrhage occurs. Use of thrombolytic agents for the treatment of acute ischemic stroke: There is very limited experience with the use of thrombolytic agents for the treatment of acute ischemic stroke in patients administered Eliquis. Patients with prosthetic heart valves: Eliquis is not recommended. Surgery and invasive procedures: Eliquis should be discontinued at least 48 hours prior to elective surgery or invasive procedures with a moderate or high risk of bleeding. Renal impairment: In patients with creatinine clearance < 15 mL/min, or in patients undergoing dialysis, there is no clinical experience therefore apixaban is not recommended. Hepatic impairment: Not recommended in patients with severe hepatic impairment. Laboratory parameters: Clotting tests (e.g., prothrombin time (PT), international normalised ratio (INR), and activated partial thromboplastin time (aPTT)) are affected as expected by the mechanism of action of apixaban. For 2.5mg - Spinal/epidural anaesthesia or puncture. **8. INTERACTIONS:** Eliquis is not recommended in patients receiving concomitant systemic treatment with strong inhibitors of both CYP3A4 and P-gp. Concomitant use of Eliquis with strong CYP3A4 and P-gp inducers may lead to a ~50% reduction in apixaban exposure. **9. PREGNANCY AND LACTATION:** There are no data from the use of apixaban in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. Apixaban is not recommended during pregnancy. It is unknown whether apixaban or its metabolites are excreted in human milk. A decision must be made to either discontinue breast-feeding or to discontinue/abstain from apixaban therapy. **10. SIDE EFFECTS:** Common: anaemia, haemorrhage, nausea, contusion and haematoma. (Please refer to the full Prescribing Information for details) Reference: Eliquis 2.5 mg and 5 mg HK Prescribing Information (July 2019) Date of preparation: Sept 2019 Identifier number: ELIQ0919 FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST

Eliquis™ apixaban

Pfizer Corporation Hong Kong Limited | 18/F Kerry Centre, 683 King's Road, Quarry Bay, Hong Kong | Tel: (852) 2811 9711 Fax: (852) 2579 0599 | Website: www.pfizercom.hk | PP-ELI-HKG-0334 JUN 2020

Pfizer Emerging Markets

Treating patients with AFundergoing PCI: finding the sweet spot of treatment

Dr.LEONG Iat Lon

澳門科技大學科大醫院 特約專科醫生 2021
澳門醫學專科學院心內科院士 2019
台北榮民總醫院心內科專科受訓醫師 2014 - 2015
中山大學中山醫學院臨床醫學 2005

專科資格
中華人民共和國 執業醫師資格
中華人民共和國 專科(心內科) 執業醫師資格
澳門醫學專科學院 心內科專科醫師資格
澳門介入心血管病學會 學術部部長
澳門心臟學會 委員
澳門臨床內科學會 委員
亞太結構性心臟病青年俱樂部 銀星會員
粵港澳大灣區心臟協會 委員

臨床醫學專長:
一般內科及危重症常見疾病處理
心臟科常見疾病: 高血壓、糖尿病、高脂血症、冠心病、心力衰竭、心肌病、心瓣膜疾病、心律不整管理及治療
心血管介入手術治療 及結構性心臟病治療
心血管病危急重症處理：前鏡湖醫院ECMO TEAM成員
心臟超聲波及食道超聲波檢查, 心臟超聲造影檢查

Treating patients with AFundergoing PCI: finding the sweet spot of treatment

Dr.LEONG Iat Lon

國際醫學期刊發表文章:

1.Characterization of Ca 2+ -Sensing Receptor-Mediated Ca 2+ Influx in Microvascular bEND.3 Endothelial Cells March 2021 The Chinese journal of physiology

2.Tannic acid, a vasodilator present in wines and beverages, stimulates Ca2+ influx via TRP channels in bEND.3 endothelial cells March 2020 Biochemical and Biophysical Research Communications 526(1)

3.Lysophosphatidylcholine-induced cytotoxicity and protection by heparin in mouse brain bEND.3 endothelial cells July 2018 Fundamental and Clinical Pharmacology 33(1)

4.Valproic acid inhibits ATP-triggered Ca 2+ release via a p38- dependent mechanism in bEND.3 endothelial cells May 2018 Fundamental and Clinical Pharmacology 32(5)

5.Attaining cholesterol goals: will aiming for lower targets improve the score?
November 2017 Current Medical Research and Opinion 34(2):1-6

6.Eicosapentaenoic acid triggers Ca2+ release and Ca2+ influx in mouse cerebral cortex endothelial bEND.3 cells November 2016 The Journal of Physiological Sciences 68(1)

7.An Extraordinary Case of Silent Extensive Anterior Wall Myocardial Infarction Complicated with Giant Left Ventricular Aneurysm and Dressler Syndrome January 2014 World Journal of Cardiovascular Diseases 04(06):294-298

REDEFINING EXPECTATIONS

For Those At Risk Of Cardiovascular Events

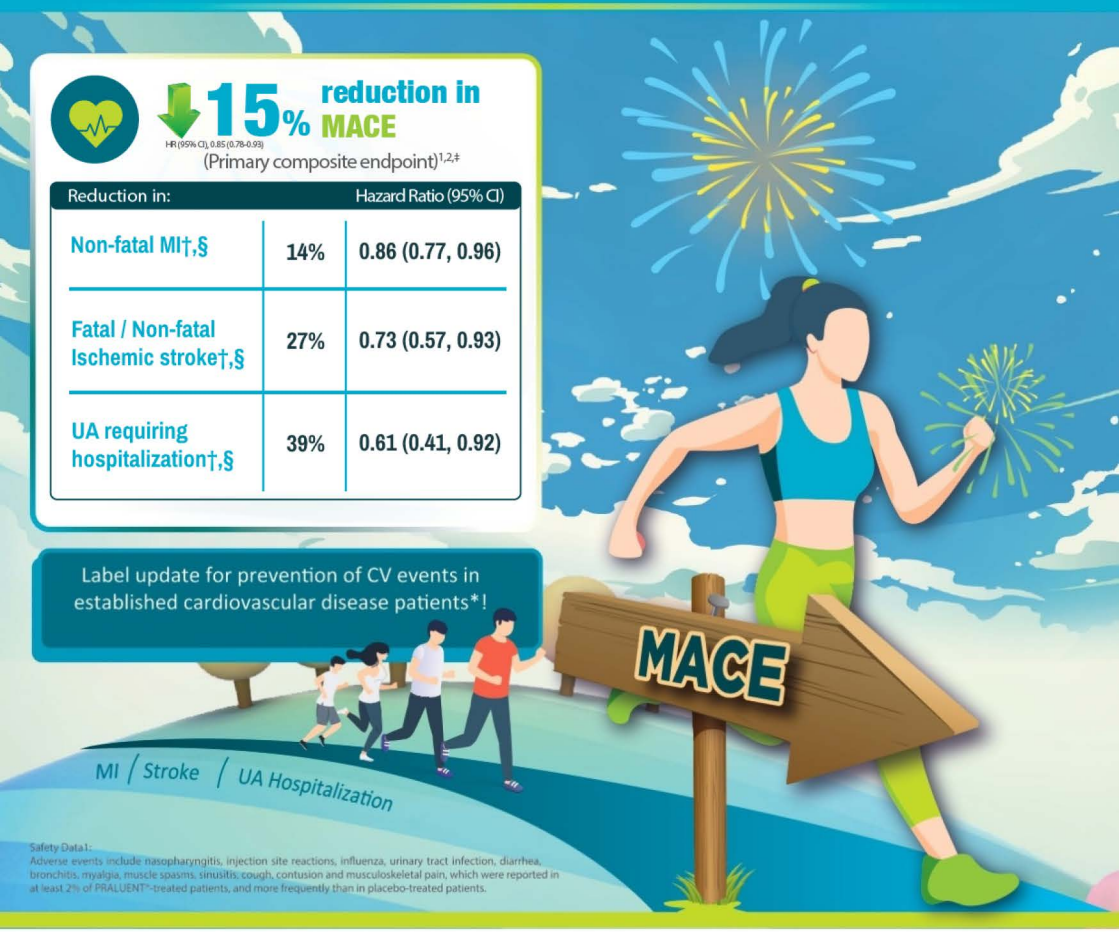
15% reduction in MACE

HR (95% CI), 0.85 (0.78-0.93)

(Primary composite endpoint)[1,2,‡]

Reduction in:		Hazard Ratio (95% CI)
Non-fatal MI†,§	14%	0.86 (0.77, 0.96)
Fatal / Non-fatal Ischemic stroke†,§	27%	0.73 (0.57, 0.93)
UA requiring hospitalization†,§	39%	0.61 (0.41, 0.92)

Label update for prevention of CV events in established cardiovascular disease patients*!



Safety Data1:
Adverse events include nasopharyngitis, injection site reactions, influenza, urinary tract infection, diarrhea, bronchitis, myalgia, muscle spasms, sinusitis, cough, contusion and musculoskeletal pain, which were reported in at least 2% of PRALUENT®-treated patients, and more frequently than in placebo-treated patients.

* PRALUENT® is indicated to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. PRALUENT® is also indicated as an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for the treatment of adults with primary hyperlipidemia to reduce low-density lipoprotein cholesterol (LDL-C).

† Statistical testing performed outside hierarchy; therefore not considered statistically significant.

‡ Primary composite endpoint of death from coronary heart disease, nonfatal myocardial infarction, fatal or nonfatal ischemic stroke, or unstable angina requiring hospitalization.

§ Major secondary end points (HR, 95% CI), in order of hierarchical testing, include any coronary heart disease event (0.88, 0.81-0.95), major coronary heart disease event (0.88, 0.80-0.96), any cardiovascular event (0.87, 0.81-0.94), composite of death from any cause, nonfatal myocardial infarction, or nonfatal ischemic stroke (0.86, 0.79-0.93), death from coronary heart disease (0.92, 0.76-1.11, the hierarchical analysis was stopped after the first nonsignificant P value was observed, in accordance with the hierarchical testing plan), death from cardiovascular causes (0.88, 0.74-1.05) and death from any cause (0.85, 0.73-0.98). To adjust for multiplicity, the results of the main secondary end points were to be tested in hierarchical fashion in the sequence listed above if the risk of the composite primary end point was found to be significantly lower in the alirocumab group than in the placebo group.

Study Design[1,2]
ODYSSEY OUTCOMES is a multicenter, randomized, double-blind, placebo-controlled trial involving 18,924 patients who had an acute coronary syndrome 1 to 12 months earlier, had a low-density lipoprotein (LDL) cholesterol level of at least 70 mg per deciliter (1.8 mmol per liter), a non–high-density lipoprotein cholesterol level of at least 100 mg per deciliter (2.6 mmol per liter), or an apolipoprotein B level of at least 80 mg per deciliter, and were receiving statin therapy at a high-intensity dose or at the maximum tolerated dose. Patients were randomly assigned to receive alirocumab subcutaneously at a dose of 75 mg (9462 patients) or matching placebo (9462 patients) every 2 weeks. The dose of alirocumab was adjusted under blinded conditions to target an LDL cholesterol level of 25 to 50 mg per deciliter (0.6 to 1.3 mmol per liter).

MACE=major adverse cardiovascular events. MI=myocardial infarction. UA=unstable angina. PCSK9=Proprotein convertase subtilisin/kexin type 9. CVD=cardiovascular disease. HeFH=Heterozygous Familial Hypercholesterolemia.

Reference:
1. Praluent® Prescribing Information. Mar 2020. 2. Schwartz GG, et al. N Engl J Med. 2018;379:2097-2107.

Presentation: Alirocumab solution for injection. Indications: Prevention of Cardiovascular Events: Reduce risk of myocardial infarction, stroke and unstable angina requiring hospitalization in adults with established cardiovascular disease. Primary Hyperlipidemia (incl. heterozygous familial hypercholesterolemia): As an adjunct to diet, alone or in combination with other lipid-lowering therapies, for the treatment of adults with primary hyperlipidemia to reduce LDL-C. Dosage: 75 mg once every 2 weeks administered subcutaneously. An alternative starting dosage for patients who prefer less frequent dosing is 300 mg once every 4 weeks. If the LDL-C response is inadequate, the dosage may be increased to the maximum dosage of 150 mg administered every 2 weeks. Contraindications: History of serious hypersensitivity reaction to alirocumab. Precautions: Hypersensitivity reactions. Pregnancy and Lactation: There are no available data on use of alirocumab in pregnant women to inform a drug-associated risk. There is no information regarding the presence of alirocumab in human milk, the effects on the breastfed infant, or the effects on milk production. Undesirable effects: Nasopharyngitis, injection site reactions, influenza, urinary tract infection, diarrhea, bronchitis, myalgia, muscle spasms, sinusitis, cough, contusion, musculoskeletal pain, flu-like illness, angioedema. For other undesirable effects, please refer to the full prescribing information. Preparation: 1 x 75mg/ml prefilled pen, 1 x 150mg/ml prefilled pen. Legal Classification: Part 1, First & Third Schedules Poison Full prescribing information is available upon request.
API-HK-ALI-20.07

MAT-HK-2101061-1.0 (09/2021) 4IC_1332

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Praluent® alirocumab

Treating angina where it matters

VASTAREL® MR
Trimetazidine
2 tablets daily

ACTS DIRECTLY AT CARDIAC CELL LEVEL

// INCREASES
ATP level by 33%[1]

// REDUCES
frequency of angina attacks[2,3]

// IMPROVES
exercise capacity[2,3]

2 tablets daily

1. Fragasso G et al. – Eur Heart J. 2006; 27:942-948. 2. SmPC VASTAREL 35 mg, modified-release film-coated tablet. 3. Glezer M, CHOICE-2 study investigators. Adv Ther. 2018;35:1103-1113.

COMPOSITION*: Vastarel 35mg, modified-release film-coated tablet containing 35mg trimetazidine. **INDICATIONS*:** Indicated in adults as add-on therapy for the symptomatic treatment of patients with stable angina pectoris who are inadequately controlled by or intolerant to first-line antianginal therapies. **DOSAGE and ADMINISTRATION*:** The dose is one tablet of 35mg of trimetazidine twice daily during meals. Benefit of the treatment should be assessed after three months and trimetazidine should be discontinued if there is no treatment response. Patients with renal impairment/elderly: In patients with moderate renal impairment (creatinine clearance [30-60] ml/mn), 1 tablet of 35mg in the morning during breakfast. **CONTRAINDICATIONS*:** Hypersensitivity to the active substance or to any of the excipients. Parkinson disease, parkinsonian symptoms, tremors, restless leg syndrome, and other related movement disorders, Severe renal impairment (creatinine clearance < 30ml/min). **WARNINGS*:** This medicine is not a curative treatment for angina attacks, nor is it indicated as an initial treatment for unstable angina or myocardial infarction, nor in the pre-hospital phase or during the first days of hospitalization. In the event of an angina attack, the coronaropathy should be reevaluated and an adaptation of the treatment considered. Trimetazidine can cause or worsen parkinsonian symptoms (tremor, akinesia, hypertonia), which should be regularly investigated, especially in elderly patients. Falls, may occur, related to gait instability or hypotension, in particular in patients taking antihypertensive treatment. **INTERACTIONS*: FERTILITY*: PREGNANCY*:** Avoid prescription. **BREASTFEEDING*:** Should not be used. **DRIVE & USE MACHINES*:** Caution because cases of dizziness and drowsiness have been observed. **UNDESIRABLE EFFECTS*:** Common: dizziness, headache, abdominal pain, diarrhoea, dyspepsia, nausea, vomiting, rash, pruritus, urticaria, asthenia. Rare: palpitations, extrasystoles, tachycardia, arterial hypotension, orthostatic hypotension that may be associated with malaise, dizziness or fall, in particular in patients taking antihypertensive treatment, flushing. Not known: parkinsonian symptoms (tremor, akinesia, hypertonia), gait instability, restless leg syndrome, other related movement disorders, usually reversible after treatment discontinuation, sleep disorders (insomnia, drowsiness), vertigo, constipation, AGEP (acute generalised exanthematous pustulosis), angioedema, agranulocytosis, thrombocytopenia, thrombocytopenic purpura, hepatitis. **OVERDOSE*: PROPERTIES*:** Trimetazidine acts as a metabolic agent, preserving the myocardial high-energy phosphate intracellular levels. Anti-ischemic effects are achieved without concomitant haemodynamic effects. **PRESENTATION*:** Pack of 60 modified-release film-coated tablets of Vastarel 35mg. **SERVIER HONG KONG LIMITED,** 31/F, Tower 5, The Gateway, 15 Canton Road, Harbour City, Tsim Sha Tsui, Kowloon, Hong Kong. **www.servier.hk** *For complete information, please refer to the complete Summary of Product Characteristics.

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VMR2303D Jan 2023

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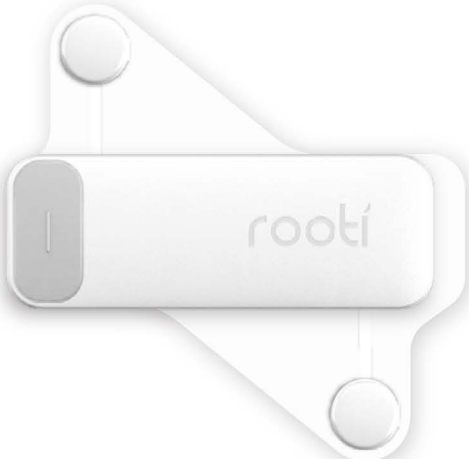
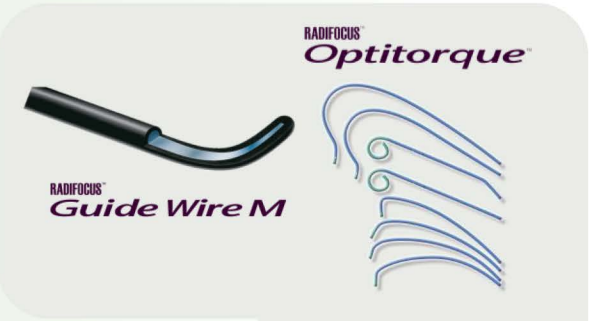
RootiRx
SYSTEM

Continuous ECG Recorder

RootiRx is a compact heart-monitoring device that captures a single-lead ECG signal continuously up to 7 days.
It's easy to wear on the chest and used comfortably in daily activities.



www.rooticare.com



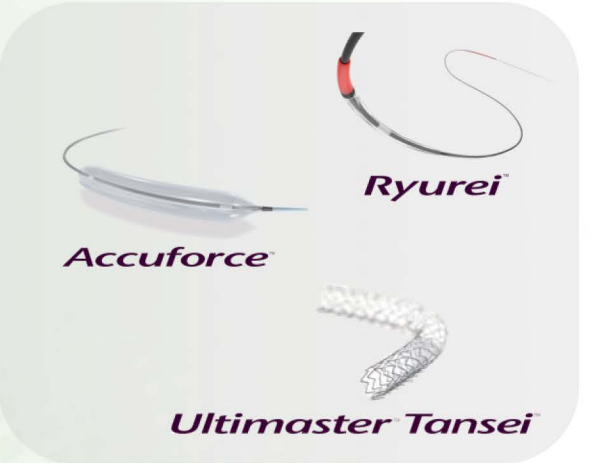
Access

Target

Intervene

Close

Total solution from Terumo
From Access to Closure



TERUMO Mekim

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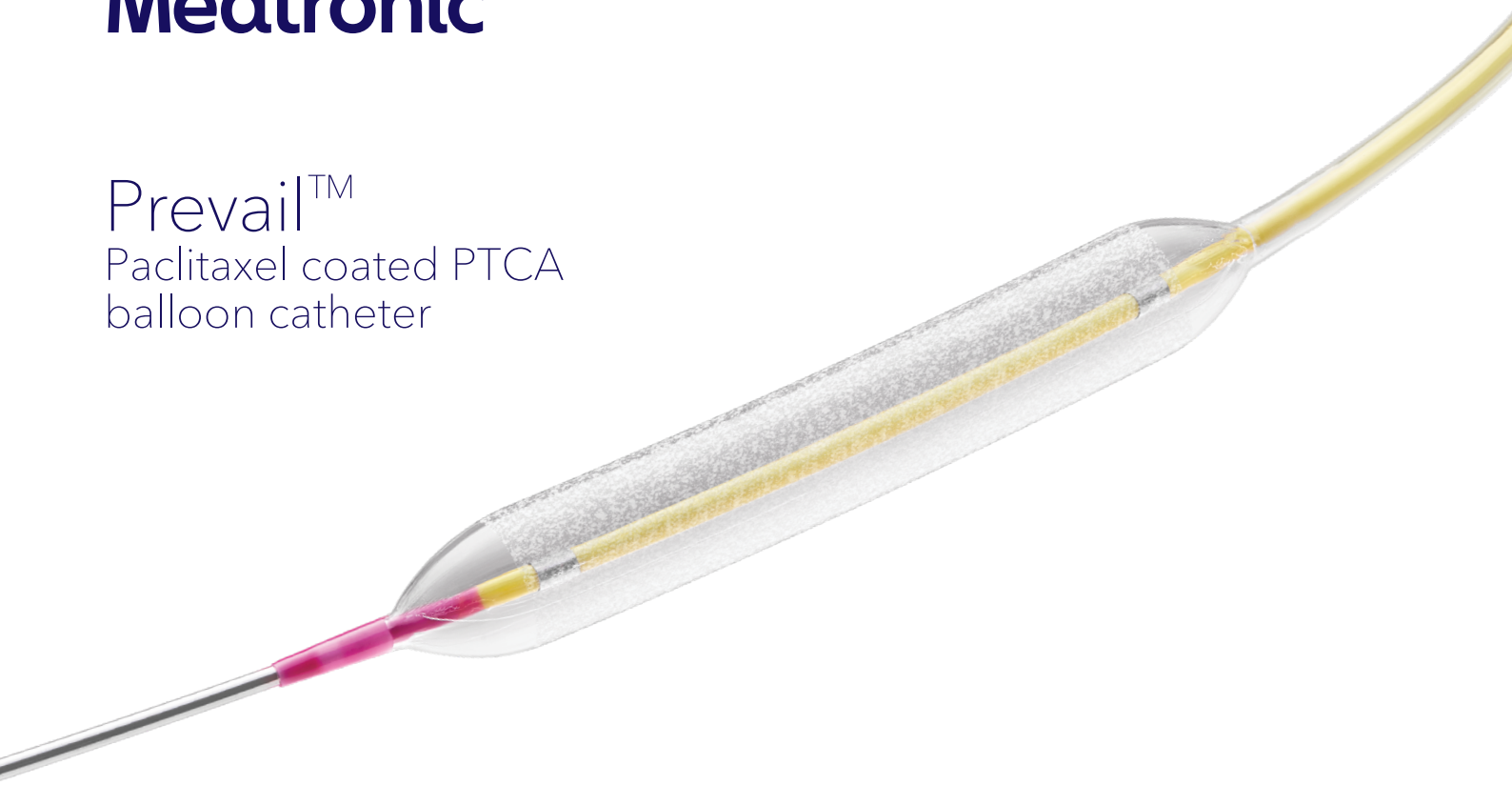
VIATRIS

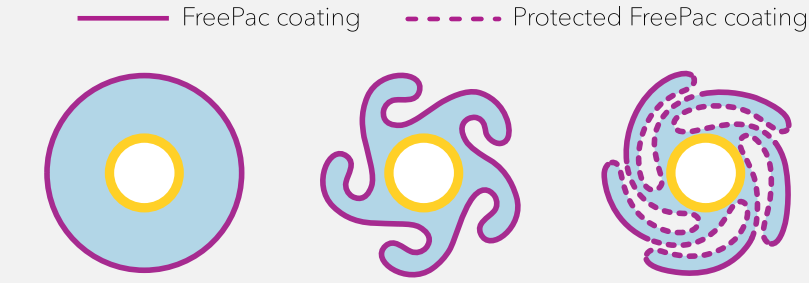
Medtronic

Prevail™

Paclitaxel coated PTCA balloon catheter



Open coating process - reliable, uniform FreePac coating.†

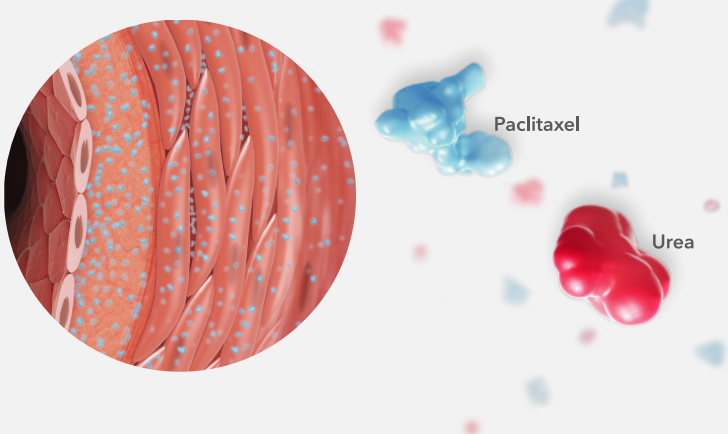


Balloon open while FreePac coating is applied

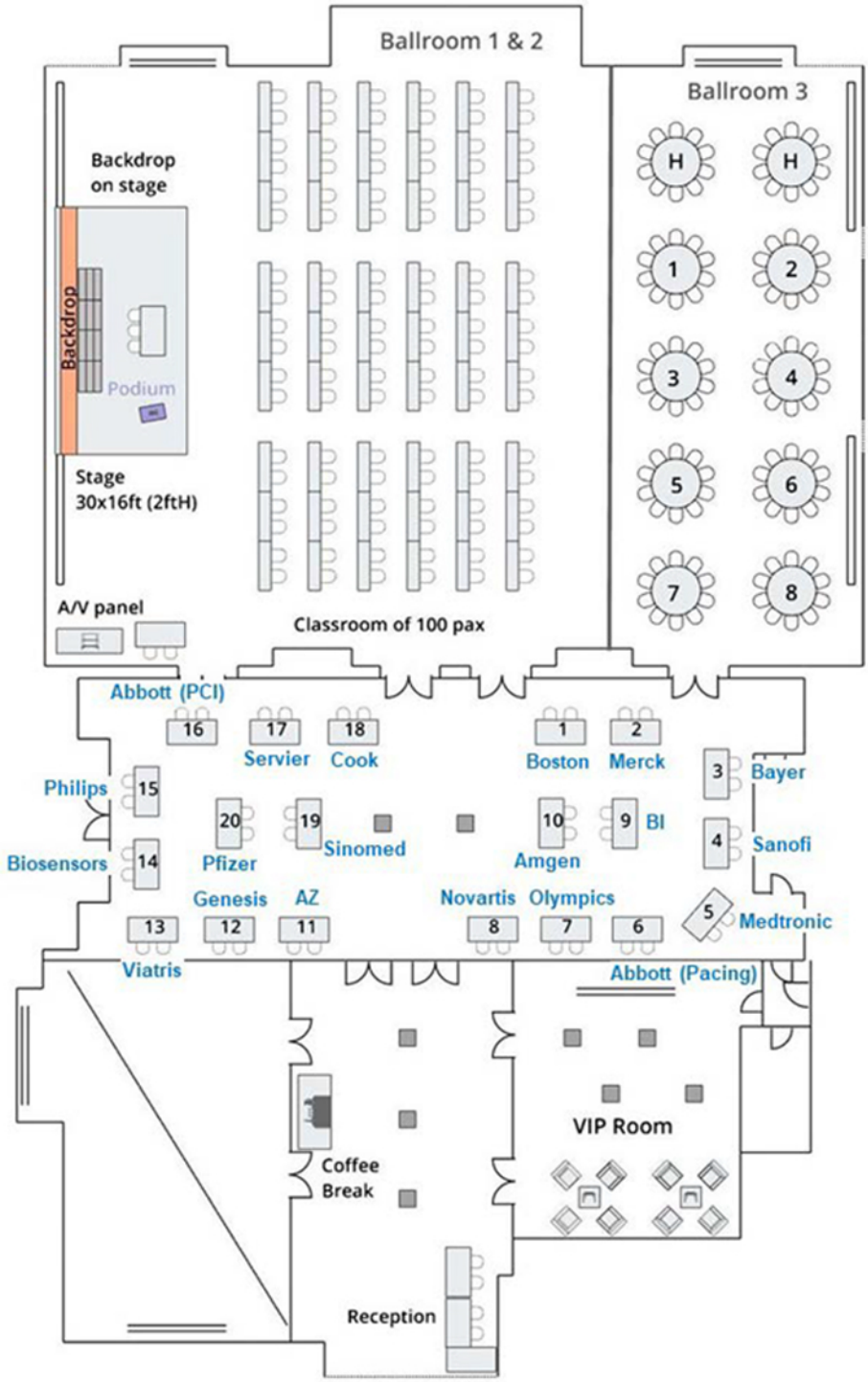
Balloon folding

65% of drug is protected within the folds [2]

Rapid absorption of Paclitaxel [1]



† Prevail Instructions for Use.
[1] Based on bench test data. Bench test data may not be indicative of clinical performance.
[2] Depending on DCB fold configuration. D00277875 report on file at Medtronic.


Ballroom 1 & 2
Ballroom 3
Backdrop on stage
Backdrop
Podium
Stage 30x16ft (2ftH)
A/V panel
Classroom of 100 pax
H
H
1
2
3
4
5
6
7
8
Abbott (PCI)
16
17
18
Servier
Cook
1
2
Boston
Merck
3
Bayer
Philips
15
20
19
Sinomed
10
9
BI
4
Sanofi
Biosensors
14
Pfizer
Amgen
Genesis
AZ
Novartis
Olympics
5
Medtronic
13
12
11
8
7
6
Viatris
Abbott (Pacing)
VIP Room
Coffee Break
Reception

Date / /

澳門介入診療學會學術年會2023

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ANNUAL SCIENTIFIC CONFERENCE 2023