Associação de Diagnóstico e de Terapêutica de Intervenção de Macau

澳門介入診療學會

Annual Scientific Conference

學術年會 2025

VENUE
MGM MACAU
GRAND BALLROOM

FEB 23
SUNDAY

Content
目錄

Welcoming Speech
主席致詞

On behalf of the Associação de Diagnóstico e de Terapêutica de Intervenção de Macau, it is our great pleasure to welcome all of you to participate in our academic conferences on 23 February 2025.

The conferences focus on the various aspects of modern management of Interventional and therapies, hot topics including Cardiology, Neurology Endocrinology and Gastroenterology. We invited experts from Europe, Mainland China, Hong Kong and Macau.

We thank for your support and hope you all enjoy Associação de Diagnóstico e de Terapêutica de Intervenção de Macau academic conferences 2025.

President,
Dr. JIN Chun

Organizing Committee
組織委員會

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Consultant	KUOK Cheong U

Annual Scientific Conference
學術年會 2025
FEB 23 SUNDAY

VENUE MGM MACAU GRAND BALLROOM

AGENDA (MEDICAL)

Emcee: Angie, Hera

Macau Valves

Section 1

Chairperson: LAM U Po, Edmundo LAO, FAN Sai Hou Alexandre

09:30 - 10:00

Eric EECKHOUT
TAVI: Current Challenges and Future Directions

10:00 - 10:30

LAM Cheung Chi, Simon
Fixing the Tricuspid Valve:
What is in and How to Select from the Toolbox?

10:30 - 10:45

Tea Break

Advances in Coronary Artery Intervention in Conjunction with Establishment of Greater Bay Chest Pain Center

Section 2

Chairperson: HUO Yong, WU Na Qiong, LIN Xue, LEONG Iat Cheng

10:45 - 11:15

高展
急性冠脈綜合症功能學應用

11:15 - 11:45

TAM Chor Cheung, Frankie
Establishing Chest Pain Center in Hong Kong

11:45 - 12:15

張岩
胸痛中心認證標準解讀及建設經驗分享

12:15 - 12:45

李承志
門靜脈及腸系上膜靜脈栓塞的介入治療

Lunch Symposium

Chairperson: KONG Soi Chau, TAM Weng Chio

13:00 - 13:30

Edmund LAU
Breathe New Air into PAH

13:30 - 14:00

WONG Man Ho, Ivan
Optimising Patient Outcome:
The Cardio-Kidney-Metabolic Matrix

Opening Speech & Group Photo

14:00 - 14:30

JIN Chun

Section 3

Chairperson: JIN Chun, FENG Xiu Hua, CHANG Tou

14:30 - 15:00

LAU Chak Kwan, Michael
From PCI to Prevention : The Importance of Aggressive Lipid Management in Reducing CV Risk

15:00 - 15:30

WONG Ka Hoi
SGLT2 Inhibitors in CKM Syndrome:
A Comprehensive Review of Cardiovascular Benefits and Future Direction

15:30 - 16:00

LEONG Iat Lon
Early LDL-C Control post ACS: Advancing Outcomes with PCSK9 inhibitors

16:00 - 16:15

Tea Break

Section 4

Chairperson: CHONG Keng San, KONG Kuan Kei, CHEANG Teng

16:15 - 16:45

Esmond FONG
Modern Treatment of Intermediate High Risk PE

16:45 - 17:15

LIAO Ting
Middle Meningeal Artery Embolization in Treatments of Chronic Subdural Hematoma

17:15 - 17:45

CHOI Kun Cheong
EUS-guided Biliary Drainage

17:45

LEUNG Ki
Closing Remarks

AGENDA (NURSING)

Emcee: Cathy Mak

Section 1

Chairperson: CHUI Sze Ling Celine, LAM Wing Kuen William, TAM Hon Lon Alan

KOU Ion Pui
Introduction

14:30 - 15:00

CHAN Wing Keung, David
The Application of Bedside Ultrasonography in Nursing

15:00 - 15:30

CHAU Mei Yi
Sharing the Establishment of Chest Pain Centre in Hong Kong: Nursing Perspective

15:30 - 16:00

CHEUNG Shuk Ting, Denise
Evidence Based Practice in Nursing

16:00 - 16:30

CHAN Kin Hei, Anthony
Overview of Hong Kong Cardiac Catherization Laboratory Service: Opportunities and Challenges

16:30 - 16:45

Tea Break

Section 2

Chairperson: CHUI Sze Ling Celine, LAM Wing Kuen William, TAM Hon Lon Alan

16:45 - 17:15

馬瑛
解鎖內地心血管介入護理密碼

17:15 - 17:45

鍾海
專利創新構想引領介入護理發展新方向

17:45 - 18:15

TAM Wai Keong, Benny
Nursing Care for Patients Receiving Interventional Cardiac Catheterisation

KOU Ion Pui
Summary

CME and CPD accreditation has been applied.

Aganda
活動議程

Associação de Diagnóstico e de Terapêutica de Intervenção de Macau

澳門介入診療學會

Section 1

TAVI: Current Challenges and Future Directions

Eric EECKHOUT

BIOGRAPHY

Senior consultant university hospital UZ VUB Brussels, Belgium

Honorary professor medical school Lausanne, Switzerland

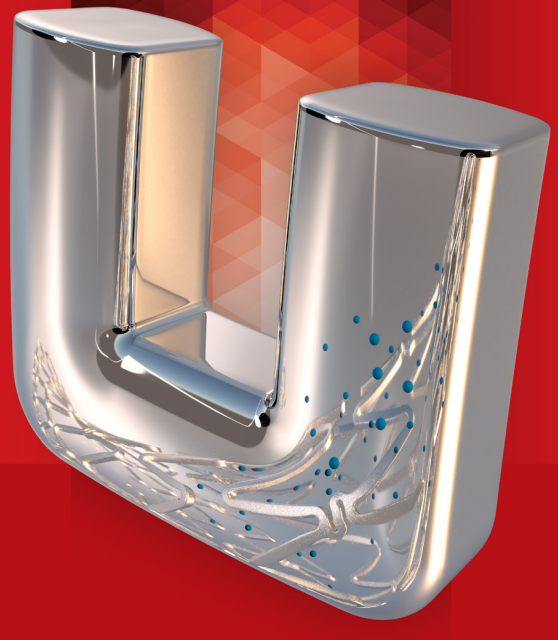
Founding editor of the EAPCI-PCR interventional cardiology textbook

Co-director of several interventional cardiology meetings

Founder of the ECC congresses

Medical

Chairperson: LAM U Po, Edmundo LAO, FAN Sai Hou Alexandre



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Section 1

Fixing the Tricuspid Valve: What is in and How to Select from the Toolbox?

林祥智

LAM Cheung Chi, Simon

MBBS (HK) FRCP (Glas) FHKCP FHKAM (MEDICINE) FACC FESC

Dr. Simon Cheung-Chi LAM (Hong Kong, China) Consultant

Queen Mary Hospital, The University of Hong Kong

BIOGRAPHY

Dr. Simon Cheung-chi Lam is Consultant Cardiologist and Honorary Clinical Associate Professor from Queen Mary Hospital, Hong Kong. He completed his medical degree in the University of Hong Kong and received his post-fellowship training in Structural and Congenital Heart Intervention in Cardiovascular Center Frankfurt, Germany under Prof. Horst Sievert in 2012-2013.

His special interests include transcatheter aortic valve implantation, percutaneous mitral and tricuspid valves repair, TMVR, TTVR, transcatheter electrosurgery, complex percutaneous coronary intervention, intracoronary imaging, and adult congenital heart disease. His latest experiences include transfemoral J-valve for pure aortic regurgitation and LUX Valve Plus Tricuspid Valve Replacement, and bench testing for innovation development and training platforms in transcatheter electrosurgery and heart valve interventions. He is the course director of QMH OCT-COE Course and annual Hong Kong Valve Conference.

Medical

Chairperson: LAM U Po, Edmundo LAO, FAN Sai Hou Alexandre

THERE'S A GROUNDBREAKING REASON TO RETHINK HOW YOU TREAT HF

FORXIGA PROTECTION IS **NOW EXTENDED** INCLUDE PATIENTS WITH HFpEF AS SHOWN IN A POOLED ANALYSIS[1-5]*

FORXIGA is recommended by the ESC as first-line therapy for symptomatic heart failure across the full range of ejection fractions[6]

FORXIGA is the only SGLT2 inhibitor proven to reduce the risk of CV death (by 14% RRR) across the ejection fraction range, on top of SoC, vs placebo[5†]

FORXIGA is recommended by the ESC in patients with diabetes at high risk of CV disease or with CV disease in order to prevent HF hospitalisations.[7]

forxiga® (dapagliflozin)

Important Disclaimers

- FORXIGA is indicated in adults for the treatment of symptomatic chronic heart failure[1]
- In DAPA-HF, the primary endpoint showed that FORXIGA administered in conjunction with other HF therapies reduced the relative risk of the composite endpoint of worsening of HF or CV death by 26% (4.9% ARR) vs placebo with other HF therapies in 4744 adult patients with HFrEF (median follow-up of 18.2 months; P<0.001).[2] In DELIVER, the primary endpoint was a composite of worsening heart failure or cardiovascular death. DELIVER showed that FORXIGA administered in conjunction with other HF therapies reduced the relative risk of the composite endpoint of worsening HF or CV death by 18% (3.1% ARR) vs placebo with other HF therapies in 6263 adult patients with HFpEF (median follow-up of 2.3 years; P<0.001).[3] In both trials, worsening of HF is defined as hHF or urgent HF visit requiring initiation or intensification of treatment specifically for HF[2,3]

*In the DAPA-HF trial, FORXIGA significantly reduced the risk of the primary composite endpoint, CV mortality alone, and all-cause mortality.[1,2] The DELIVER trial, which included recently hospitalised patients in addition to patients with ejection fraction >40%, was the largest and broadest trial in patients with heart failure.[3,4] In DELIVER, FORXIGA significantly reduced risk of the primary composite endpoint but did not reach significance in CV death alone or all-cause mortality.[3] In a prespecified pooled analysis of the DAPA-HF and DELIVER trials, FORXIGA significantly reduced risk of CV mortality and all-cause mortality.[5]

†A patient-level pooled meta-analysis of two trials testing dapagliflozin in participants with heart failure and different ranges of left ventricular ejection fraction (≤40% and >40%)/ The pre-specified endpoints were: death from cardiovascular causes; death from any cause; total hospital admissions for heart failure; and the composite death from cardiovascular causes, myocardial infarction or stroke (major adverse cardiovascular events (MACEs)). A total of 11,007 participants with a mean ejection fraction of 44% (s.d. 14%) were included. Dapagliflozin reduced the risk of death from cardiovascular causes (hazard ratio (HR) 0.86, 95% confidence interval (CI) 0.76-0.97; P=0.01), death from any cause (HR 0.90, 95% CI 0.82-0.99; P=0.03), total hospital admission for heart failure (rate ratio 0.71, 95% CI 0.65-0.78; P<0.001) and MACEs (HR 0.90, 95% CI 0.81-1.00; P=0.045).[5]

ARR, absolute risk reduction; CI, confidence interval; CV, cardiovascular; ESC, European Society of Cardiology; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; hHF, hospitalisation for heart failure; HR, hazard ratio; MACE, major adverse cardiovascular events; RRR, relative risk reduction; s.d., standard deviation; SGLT2, sodium-glucose co-transporter 2; SoC, standard of care.

References: 1. FORXIGA 10 mg film-coated tablets. Hong Kong Prescribing Information. December 2023. 2. McMurray JJV, et al. *N Engl J Med.* 2019;381(21):1995–2008. 3. Solomon SD, et al. *N Engl J Med.* 2022;387(12):1089–1098. 4. Solomon SD, et al. *JACC Heart Fail.* 2022;10(3):184–197. 5. Jhund PS, et al. *Nat Med.* 2022;28(9):1956–1964. 6. McDonagh TA, et al. *Eur Heart J.* 2023;00:1-13. 7. McDonagh TA, et al. *Eur Heart J.* 2021;42:3599-3726.

Abbreviated Prescribing Information
FORXIGA
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. 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 improvement if 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; patients with infiltrative cardiomyopathy have not been studied; 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, tubulointerstitial nephritis. Not known: acute kidney injury. **Drug interaction:** Coadministration with rifampicin may reduce dapagliflozin systemic exposure; coadministration with mefenamic acid may increase dapagliflozin systemic exposure; dapagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. Serum concentration of lithium should be monitored more frequently after dapagliflozin initiation and dose changes. 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.HK.FOR.1223**

Please email us at HKPatientSafety@astrazeneca.com, for (1) enquiring Medical Information (MI), (2) reporting Individual Case Safety Report (ICSR) and/or (3) reporting Product Quality Complaint (PQC).

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急性冠脈綜合症功能學應用

高展
GAO Zhan

BIOGRAPHY

主任醫師，醫學博士，碩士研究生導師，阜外心血管病醫院冠心病中心副主任。中華醫學會心血管臨床研究學組成員，中國醫師協會心血管內科醫師分會委員，老年醫學學會心血管病分會委員。

主要從事冠狀動脈研究和介入治療工作，對冠心病介入治療積累了較豐富的經驗，尤其對冠狀動脈分叉病變和左主幹病變領域，多次參加國內外的經驗交流和合作。

第一作者在國內外的核心期刊期刊發表論文40餘篇，其中英文SCI文章25篇，作為主編、副主編和筆者參與多部專著的編寫。

Medical

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LEQVIO®
inclisiran

UNITED FOR LONG-LASTING† LDL-C CONTROL[1]

LEQVIO is administered every 6 months* and provides effective LDL-C control, supported by up to 6+ years of data[1,2]

52%▼

Effective & Sustained LDL-C Reduction[1,3]

LEQVIO demonstrated a 52% LDL-C reduction at month 17 compared to placebo, with 54% LDL-C reduction sustained from months 3-18 compared to placebo.[1,6]

6+ YEARS

Up to 6+ Years of Safety Data[2§]

LEQVIO has 6+ years of clinical data that support the safety and tolerability profile of LEQVIO, with no new safety signals observed.[2]

2 DOSES

2 Doses a Year[1*]

Administered by a healthcare provider every 6 months

* Two doses a year after the two initial doses. Single subcutaneous injection at the start of treatment, again at 3 months, and thereafter every 6 months.[1] : † LDL-C reduction was maintained during each 6-month dosing interval after 2 initial doses of incliisiran. : §Most common (>1 to <10%) adverse events at the injection site (includes injection site reaction, injection site pain, injection site erythema, and injection site rash).

References: 1. LEQVIO, Hong Kong Prescribing Information. Novartis Pharmaceuticals Corp. 2021. **2.** RS Wright, FJ Raal, W Koenig, U Landmesser, LA Leiter, S Vikarunnessa, A Lesogor, P Maheux, Z Talloczy, X Zang, GG Schwartz, KK Ray, Inclisiran administration potently and durably lowers LDL-C over an extended-term follow-up: the ORION-8 trial, Cardiovascular Research, 2024;, cvae109, https://doi.org/10.1093/cvr/cvae109. **3.** 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. doi:10.1056/NEJMoa1912387.

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:** P1S1S3 Last revision: Sep 2021 Ref: EU Dec 2020.

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Section 2

Establishing Chest Pain Center in Hong Kong

TAM Chor Cheung, Frankie

BIOGRAPHY

Dr Frankie Tam graduated from the University of Hong Kong in 2005. He received his training in Cardiology in Queen Mary Hospital Hong Kong and went to Harrington Heart and Vascular Institute, Cleveland, USA for overseas training in advanced interventional cardiology. He is currently the Consultant in Queen Mary Hospital and Honorary Clinical Associate Professor in University of Hong Kong. His special interest is in management of acute coronary syndrome, complex coronary intervention and structural heart disease intervention.

Medical

Chairperson: HUO Yong, WU Na Qiong, LIN Xue, LEONG Iat Cheng

A ONCE-MONTHLY PEN THAT'S PATIENT-FRIENDLY AND QUICK[2,4]

Praluent®
alirocumab

Unique[¥] once-monthly pen for your patients requiring >60% LDL-C reduction[2,4]

- **Button-free** device for easier administration[2]

Proven Power and Safety of PRALUENT[1-3]:

- ☑ **Intensive, fast, and sustained** LDL-C reduction[1,2*]
  - **>62%** LDL-C reduction
  - Maximum effect at **4 weeks**
  - **Sustained** over 4 years
- ☑ **Significantly reduced MACE** risk
  - **15%** MACE reduction[1]
- ☑ **Demonstrated** to get patients to LDL-C goal[3‡]
  - **95%** of ACS patients reached LDL-C goal[3]
- ☑ **Established,** long-term safety profile[1,5]
- ☑ **Only 1 injection per month** with 300mg Sydney device[2,4]

*PRALUENT significantly reduced risk of MACE (primary endpoint) in the overall trial population (N=18,924) in the ODYSSEY OUTCOMES trial (15% RRR, HR 0.85 (95% CI 0.78, 0.93), *P*=0.0003). 62.7% LDL-C reduction compared to placebo at 4 months in ODYSSEY OUTCOMES trial. 4 weeks to reach maximal effect based on a summary of ten phase 3 trials (five placebo-controlled, five ezetimibe-controlled) in high and very high-CV-risk patients. LDL-C reduction was sustained at 54.5% relative to placebo at 4 years in patients following an ACS event in the ODYSSEY OUTCOMES trial.[1,2] ‡A post hoc assessment using data from the ODYSSEY OUTCOMES trial. With PRALUENT, 94.6% of patients achieved LDL-C, 1.4 mmol/L at ≥1 post-baseline measurement vs. 17.3% with placebo.[3] ¥For patients requiring LDL-C reduction >60%, PRALUENT is the only PCSK9i with once-monthly single injection in a pre-filled pen.[2]

ACS = acute coronary syndrome; **CI** = confidence interval; **CVOT** = cardiovascular outcomes trial; **HR** = hazard ratio; **LDL-C** = low-densitylipoprotein cholesterol; **LLT** = lipid-lowering therapy; **MACE** = major adversecardiovascular event; **PCSK9I** = proprotein convertase subtilisin/kexin type 9inhibitor; **RRR** = relative risk reduction.

Reference: 1. Schwartz GG, Steg PG, Szarek M, et al. Alirocumab and cardiovascular outcomes after acute coronary syndrome. N Engl J Med. 2018;379(22):2097-2107. **2.** PRALUENT 300mg Hong Kong Prescribing Information Jun 2022. **3.** Landmesser U, McGinniss J, Steg PG, et al. Achievement of ESC/EAS LDL-C treatment goals after an acute coronary syndrome with statin and alirocumab. Eur J Prev Cardiol. 2022:29(14):1842-1851. **4.** Frias JP, Koren MJ, Loizeau V, et al. The SYDNEY device study: a multicenter, randomized open-label usability study of a 2-mL alirocumab autoinjector device. Clin Ther. 2020;42(1):94-107. **5.** Goodman SG, Steg PG, Poulouin Y, et al. ODYSSEY OUTCOMES Investigators. Long-Term Efficacy, Safety, and Tolerability of Alirocumab in 8242 Patients Eligible for 3 to 5 Years of Placebo-Controlled Observation in the ODYSSEY OUTCOMES Trial. J Am Heart Assoc. 2023 Sep 19;12(18):e029216.

PRALUENT Abbreviated Prescribing Information

Presentation: Alirocumab solution for injection. **Indications:** Primary hypercholesterolaemia (heterozygous familial and non-familial) and mixed dyslipidaemia: In adults as an adjunct to diet, in combination with a statin or statin with other lipid lowering therapies in 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 patients who are statin-intolerant, or for whom a statin is contraindicated. Established atherosclerotic cardiovascular disease: In adults to reduce cardiovascular risk by lowering LDL-C levels, as an adjunct to correction of other risk factors, in combination with the max. tolerated dose of a 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 a statin is contraindicated. **Dosage & Administration:** Subcutaneous injection into thigh, abdomen or upper arm. Rotate injection site with each injection. Do not inject into areas of active skin disease, injury, or skin infections. Exclude secondary causes of hyperlipidaemia or mixed dyslipidaemia before initiating alirocumab. 75 mg once every 2 weeks (Q2W). Patients requiring larger LDL-C reduction (>60%) may be started on 150 mg Q2W, or 300 mg Q4W. If additional LDL-C reduction is needed in patients treated with 75 mg Q2W or 300 mg Q4W, dosage may be adjusted to the max. dosage of 150 mg Q2W. If a dose is missed, administer the injection asap and thereafter resume treatment on the original schedule. Alirocumab has not been studied in paediatric patients < 8 years of age. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (Histidine, Sucrose, Polysorbate 20, Water for injections). **Precautions:** Allergic reactions: If signs or symptoms of serious allergic reactions occur, discontinue alirocumab and initiate symptomatic treatment. Renal or hepatic impairment: Use with caution in patients with severe renal or hepatic impairment. **Drug Interactions:** Statins and other lipid-modifying therapy can lead to increased target-mediated clearance and reduced systemic exposure of alirocumab. **Pregnancy, Lactation and Fertility:** No data from Praluent use in pregnant women. Alirocumab is expected to cross the placental barrier. Praluent use is not recommended during pregnancy unless clinical condition of the woman requires alirocumab treatment. It is not known whether alirocumab is excreted in human milk. IgG is excreted in human milk, in particular in colostrum; Praluent use is not recommended in breast-feeding women during this period. No data on adverse effects on fertility in humans. **Undesirable effects:** Local injection site reactions, upper respiratory tract signs & symptoms, pruritis. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 1 x 75mg/ml, 1 x 150mg/ml, 1 x 300mg/2ml prefilled pen. **Legal Classification:** Part 1, First & Third Schedules Poison **Full prescribing information is available upon request.** API-HK-ALI-22.09

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MAT-HK-2300853-1.0-09/2024

Section 2

胸痛中心認證標準解讀及建設經驗分享

張岩
ZHANG Yan

BIOGRAPHY

北京大學第一醫院; 主任醫師、教授、博士生導師; 心血管內科主任、心血管疾病研究所副所長、高血壓精準診療研究中心副主任。

擔任中華醫學會心血管病學分會精準心血管病學學組委員、中國醫師協會心血管內科醫師分會委員、北京醫學會心血管病學分會委員、中國醫藥創新促進會心血管藥物臨床研究專委會副主任委員兼秘書長、中國醫藥教育協會健康管理專業委員會副主任委員、中國醫療保健國際交流促進會心血管健康醫學分會副主任委員/老年健康醫學分會常務委員兼秘書長、 亞洲心臟病學學會理事、npj Cardiovascular Health雜誌副主編等社會職務。長期從事高血壓、心血管遺傳流行病的臨床與研究工作; 承擔十四五科技部國家重點研發計劃課題、國家自然科學基金面上專案、北京市自然科學基金等課題; 發表 SCI 論文240餘篇，核心期刊論文90餘篇。

參與高血壓腦卒中一級預防研究，獲2016年國家科學技術進步獎二等獎（第4完成人）、教育部科學技術進步獎一等獎（第4完成人）等多項獎勵。

Medical

Chairperson: HUO Yong, WU Na Qiong, LIN Xue, LEONG Iat Cheng


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Section 2

門靜脈及腸系上膜靜脈栓塞的介入治療

李承志
LI Cheng Zhi

暨南大學附屬第一醫院

介入血管外科 副主任 糖尿病足診療中心 主任

釔90肝臟腫瘤介入治療中心 副主任

副主任醫師 醫學博士 碩士研究生導師

BIOGRAPHY

美國哈佛大學醫學院Beth Israel Deaconess 醫學中心訪問學者

德國弗萊堡大學Bard krozingen心血管治療中心訪問學者

發表SCI文章30餘篇，負責國家級課題1項，廣東省級科技專案4項

現任廣東省醫院管理協會介入分會 副主任委員

廣東省精準醫學應用學會精準介入分會 副主任委員

廣州市醫師學會血管外科分會 副主任委員

廣東省精準醫學應用學會周圍血管疾病分會 常委 秘書長

廣東省醫師學會血管外科分會 常委

廣東省醫師學會介入分會 常委

廣東省臨床醫學學會血管外科專業委員會 常委

廣東省醫院管理學會血管疾病診療委員會 常委

廣東省基層醫藥學會介入醫學專業委員會 常委

國際血管聯盟中國分會青委會 常委及多個學會委員

從事外周血管及腫瘤介入治療10餘年

Medical

Chairperson: HUO Yong, WU Na Qiong, LIN Xue, LEONG Iat Cheng

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

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

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

Lunch Symposium

Breathe New Air into PAH

Edmund LAU

Senior Staff Specialist,
Department of Respiratory and Sleep Medicine
Royal Prince Alfred Hospital (RPAH);
Clinical Associate Professor,
Central Clinical School, University of Sydney
Sydney, Australia

BIOGRAPHY

Prof Edmund MT Lau is a Senior Staff Specialist in Respiratory and Sleep Medicine at Royal Prince Alfred Hospital (RPAH), Sydney, and a Clinical Associate Professor at the University of Sydney. He holds a PhD in pulmonary vascular disease from the University of Sydney. With over 15 years of expertise in pulmonary hypertension and respiratory medicine, he has made significant contributions to advancing diagnostics and clinical practices in these fields.

Widely recognized for his contributions to pulmonary medicine, Prof Lau has redefined diagnostic criteria for pulmonary hypertension, which were incorporated into the 2022 ESC/ERS Guidelines. He also validated minimally invasive lung biopsy techniques, which are now included in the 2022 ATS guidelines for interstitial lung disease. He has authored over 100 peer-reviewed publications in high-impact journals, including Lancet Respiratory and Circulation, achieving an h-index of 31 and over 3,900 citations.

Medical

Chairperson: KONG Soi Chau, TAM Weng Chio

As Medical Director of the ANZ Pulmonary Hypertension Registry, Prof Lau manages one of the largest pulmonary vascular disease registries globally, facilitating epidemiological research and improving clinical care. He has secured over $3 million in research funding and serves as Associate Editor of Respirology. A leader in pulmonary hypertension, he holds prominent roles in national and international committees, mentors PhD candidates, and plays a key role in medical education and curriculum development at the University of Sydney.

ABSTRACT

The STELLAR phase 3 trial investigated Sotatercept, a first-in-class Activin Signalling Inhibitor (ASI), in combination with background therapy for the treatment of Pulmonary Arterial Hypertension (PAH) in adults with WHO Functional Class (FC) II-III. PAH is driven by vascular remodelling due to imbalances in BMPR-II and ActRIIA-mediated pathways, resulting in luminal narrowing and increased vascular proliferation. Sotatercept is designed to reverse these changes by rebalancing signalling pathways and restoring vascular homeostasis. In this double-blind, placebo-controlled trial, Sotatercept significantly improved the placebo-adjusted 6-minute walk distance (6MWD) at 24 weeks (+40.8 m; 95% CI, 27.5–54.1; $p<0.001$). Clinical benefits extended across multiple domains, including haemodynamic, WHO functional class, biomarkers such as NT-proBNP, and patient-reported outcomes. Sotatercept also reduced the risk of death or non-fatal clinical worsening events by 84% compared with placebo (HR: 0.16; 95% CI, 0.08–0.35). Adverse events such as minor bleeding, telangiectasia, and increased haemoglobin levels occurred more frequently with Sotatercept but were manageable and well tolerated. These findings establish Sotatercept as a promising therapeutic option for PAH, delivering significant clinical and functional improvements beyond standard care.

Lunch Symposium

Optimising Patient Outcome: The Cardio-Kidney-Metabolic Matrix

WONG Man Ho, Ivan

MBBS(HK), MRCP(UK), FHKCP, FHKAM(Medicine), FACC

BIOGRAPHY

Dr Ivan Wong graduated from the University of Hong Kong in year 2012 and received his training in cardiology in Queen Elizabeth Hospital. He then further underwent one year training in structural heart interventions and interventional echocardiography in the Heart Centre, Rigshospitalet, Copenhagen, Denmark in year 2020.

He has special interest in complex structural heart interventions and device innovations. His research interest includes TAVI, LAAO and ICE-guided procedures. He established ICE-guided interventional services in regional areas including Macau and Taiwan. He authored and co-authored book chapters and publications in peer-reviewed journals including JACC cardiovascular interventions and EuroIntervention.

Medical

Chairperson: KONG Soi Chau, TAM Weng Chio

ABSTRACT

Cardiovascular Kidney Metabolic (CKM) Syndrome represents a multifaceted interplay between cardiovascular health, renal function, and metabolic disorders, posing significant challenges in clinical management. This lecture aims to elucidate the intricate relationships among these systems and highlight the cardiologist's role in the comprehensive care of affected patients.

Recent studies have shown that cardiovascular disease (CVD) and chronic kidney disease (CKD) share common risk factors, including hypertension, diabetes, and dyslipidemia, leading to a bidirectional relationship where each condition exacerbates the other. The pathophysiological mechanisms driving CKMD involve inflammation, oxidative stress, and endothelial dysfunction, which contribute to the progression of both cardiac and renal impairment.

Early identification and intervention in CKMD are crucial. This lecture will discuss risk stratification strategies, emphasizing the importance of regular cardiovascular assessments in patients with CKD. Additionally, the lecture will review contemporary therapeutic approaches, including the role of sodium-glucose cotransporter 2 (SGLT2) inhibitors and other medication, which have shown promise in mitigating cardiovascular and renal outcomes. A patient-centered approach to managing comorbidities will be discussed, emphasizing lifestyle modifications and multidisciplinary collaboration.

Section 3

From PCI to Prevention : The Importance of Aggressive Lipid Management in Reducing CV Risk

LAU Chak Kwan, Michael

MBBS (HK), MRCP (UK), FHKCP, FHKAM (Medicine)

BIOGRAPHY

Dr. Lau is an experienced cardiologist and physician with over 10 years of experience. Specializing in both general internal medicine and general cardiology, Dr. Lau has developed a broad skill set that includes exercise treadmill testing, cardiac echography, and 24-hour Holter monitoring. His expertise extends to advanced procedures such as percutaneous coronary interventions, pacemaker and implantable cardioverter defibrillator implantation, as well as electrophysiology and catheter ablation.

Dr. Lau earned his Bachelor of Medicine and Bachelor of Surgery (MBBS) from the University of Hong Kong. He is a distinguished Fellow of the Hong Kong Academy of Medicine (FHKAM) and the Hong Kong College of Physicians (FHKCP), and he holds membership in the Royal Colleges of Physicians of the United Kingdom (MRCP UK).

In addition to his clinical practice, Dr. Lau actively participates in medical education. Since 2018, he has contributed to the training of healthcare professionals through various educational activities, including the Post-registration Certificate Course in Cardiac Care Nursing and the Post-registration Certificate Course in Advanced Medical Nursing.

Medical

Chairperson: JIN Chun, FENG Xiu Hua, CHANG Tou

ABSTRACT

Coronary artery disease remains a leading cause of morbidity and mortality, particularly in patients undergoing percutaneous coronary intervention (PCI). While PCI effectively alleviates acute symptoms, it does not address the underlying dyslipidemia contributing to atherosclerosis. This lecture will emphasize the critical role of aggressive lipid management in the post-PCI setting to prevent recurrent cardiovascular events.

Recent guidelines advocate for intensive lipid-lowering therapies, particularly targeting LDL-C levels. Evidence from clinical trials demonstrates that achieving optimal LDL-C goals significantly reduces the risk of major adverse cardiovascular events in post-PCI patients. The introduction of PCSK9 inhibitors has revolutionized lipid management, offering robust LDL-C reductions and promoting plaque stabilization.

This lecture will explore the mechanisms by which aggressive lipid management enhances cardiovascular protection, the impact of newer therapies, and the importance of personalized treatment strategies. By transitioning from a reactive to a proactive approach in lipid management, healthcare providers can significantly improve long-term outcomes for post-PCI patients, ultimately transforming the paradigm of secondary prevention in cardiovascular care.

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	X Pain medication	
	X Foley catheter UTI's	
	X Access-site complications	

SOURCE: S. Verma. Adopting a Strategy of Early Ambulation and Same-Day Discharge for Atrial Fibrillation Ablation Cases - *EP Lab Digest* - May 2019.

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Section 3

SGLT2 Inhibitors in CKM Syndrome: A Comprehensive Review of Cardiovascular Benefits and Future Direction

Dr. WONG Ka Hoi

BIOGRAPHY

1984-1990

Jinan University Medical College

1991-1992

Research assistance department of BMT Queen Mary Hospital

1993-2013

Resident to chief of endocrine and diabetes department in Kiang Wu Hospital

2013-now

Private clinics, specialists of endocrine and diabetes

2019-now

Fellow of Academia Médica de Macau (Endocrinology and Metabolic Diseases)

2022- now

Faculty Affairs Committee Member of Academia Médica de Macau (Endocrinology & Metabolism Division)

Medical

Chairperson: JIN Chun, FENG Xiu Hua, CHANG Tou

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LDL-C†,9

38.0%

* Placebo-corrected reduction in LDL-C level from baseline to week 12 by individual clinical studies on bempedoic acid in patients with maximally tolerated statins: −7.4%(95% CI: −21% to +3.9%) for CLEAR Wisdom study; −11.1%(95% CI: −20% to −1.1%) for CLEAR Harmony study; all p = 0.001 vs. placebo.[5,6] † Placebo-corrected reduction in LDL-C level by individual clinical studies on bempedoic acid in statin-intolerant patients: −21.4% (95% CI: −35.1% to −7.7%) for CLEAR Serenity study; −30.6% (95% CI: −45.4% to −15.9%) for CLEAR Tranquility study; all p = 0.001 vs. placebo.[7]

‡ As the percentage change in LDL-C on top of maximally tolerated statins, compared to placebo (95% CI: −24.5% to −20.4%); p < 0.0001.[8]

Study design: CLEAR Wisdom[5] was a 52-week phase 3, investigator, double-blind, placebo-controlled study in 779 patients at high risk for ASCVD, heterozygous familial hypercholesterolaemia or both, receiving maximally tolerated statins, with or without additional LLT. CLEAR Harmony[6] was a 52-week phase 3, randomised, double-blind, placebo-controlled study in 2,230 patients at high risk for ASCVD, heterozygous familial hypercholesterolaemia or both, receiving maximally tolerated statins, with or without additional LLT. In patients in the CLEAR Harmony and CLEAR Wisdom studies were randomised to receive bempedoic acid 180 mg once daily in the active group, or matching placebo in the control group. The primary efficacy endpoint for CLEAR Wisdom, and the principal secondary endpoint for CLEAR Harmony study was the percentage change from baseline in LDL-C level at week 12. CLEAR Serenity[7] was a 24-week phase 3, randomised, double-blind, placebo-controlled study of 345 patients required additional lipid-lowering for primary and secondary prevention of CV events, who have a history of statin intolerance. Patients received once-daily oral bempedoic acid 180 mg once daily in the active group, or matching placebo in the control group. CLEAR Tranquility[8] was a 12-week phase 3, randomised, double-blind, placebo-controlled study of 269 primary and secondary prevention patients with statin intolerance, receiving ezetimibe with low-dose, very-low dose or no statins with or without other non-statin LLT. Patients were randomised to bempedoic acid 180 mg or placebo once daily added to ezetimibe 10 mg/day. The primary efficacy endpoint for CLEAR Serenity and CLEAR Tranquility studies was the percentage change from baseline in LDL-C level at week 12.

Study design: FDC Study 050 was a phase 3, double-blind, clinical trial enrolled adult patients at high CVD risk due to ASCVD, heterozygous familial hypercholesterolaemia or multiple CVD risk factors, who received stable maximally tolerated statins, 260 eligible patients were randomly assigned (1:1:1) to oral, once-daily treatment with fixed-dose bempedoic acid 180 mg and ezetimibe 10 mg (n = 106), bempedoic acid 180 mg (n = 110), ezetimibe 10 mg (n = 108) or placebo (n = 86) for 12 weeks. The primary endpoint was the percentage change in LDL-C from baseline to week 12.

ACL = ATP-citrate lyase; ASCVD = atherosclerotic cardiovascular disease; CI = confidence interval; CVD = cardiovascular disease; EU = European Union; FDC = fixed-dose combination; LDL-C = low density lipoprotein-cholesterol; LLT = lipid-lowering therapy; US = United States.

References: 1. Banach M, Penson PE, Farnier M, et al. Prog Cardiovasc Dis. 2023;80:80-93.2023030035-6. 2. NILEMDO® (bempedoic acid) tablets 180 mg Prescribing Information, Hong Kong Mar 2023. 3. NUSTENDI® (bempedoic acid/ezetimibe) tablets 180 mg/10 mg Prescribing Information, Hong Kong Mar 2023. 4. Markham A, Drugs. 2020;80(7):747-753. 5. Goldberg AC et al. JAMA. 2019; 322(18): 1780–1788. 6. Ray KK et al. N Engl J Med. 2019; 380: 1022–1032. 7. Laufs U et al. J Am Heart Assoc. 2019; 8:e012662. 8. Gutierrez CM et al. Atheroscler Plus. 2019; 37: 1–10.9. Du Cheyron CM et al. Eur J Prev Cardiol. 2022; 29(5): 883–892.

Abbreviated Prescribing Information

Nilemdo Abbreviated Prescribing Information

Nilemdo (bempedoic acid) tablets 180 mg. Indications: Nilemdo is an adenosine triphosphate-citrate lyase (ACL) inhibitor indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolaemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C. Dosage and Administration: Administer 180 mg orally once daily with or without food. Contraindications: None. Warnings and Precautions: May increase blood uric acid levels. Assess uric acid levels periodically as clinically indicated. Monitor for signs and symptoms of hyperuricemia, and initiate treatment with urate-lowering drugs as appropriate. Tendon Rupture: Nilemdo is associated with an increased risk of tendon rupture or injury. Discontinue Nilemdo at the first sign of tendon rupture. Avoid Nilemdo in patients who have a history of tendon disorders or tendon rupture. Pregnancy and lactation. Adverse Reactions: Most common: upper respiratory tract infection, muscle spasms, hyperuricemia, back pain, abdominal pain or discomfort, bronchitis, pain in extremity, anemia, and elevated liver enzymes. Others include tendon rupture, gout, benign prostatic hyperplasia, and flu-like illness. Drug Interactions: Simvastatin: Avoid concomitant use of Nilemdo with simvastatin greater than 20 mg. Pravastatin: Avoid concomitant use of Nilemdo with pravastatin greater than 40 mg.

Nustendi Abbreviated Prescribing Information

Nustendi (bempedoic acid and ezetimibe) tablets 180 mg/ bempedoic acid/ 10 mg ezetimibe. Indications: Nustendi is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolaemia or established atherosclerotic cardiovascular disease who require additional lowering of LDL-C. Dosage and Administration: Administer one tablet (180 mg bempedoic acid and 10 mg ezetimibe) orally once daily with or without food. Swallow the tablet whole. Contraindication with bile acid sequestrants. Administer at least 2 hours before or at least 4 hours after bile acid sequestrants. Contraindications: Known hypersensitivity to ezetimibe tablets. Warnings and Precautions: Hyperuricemia: May increase blood uric acid levels. Assess uric acid levels periodically as clinically indicated. Monitor for signs and symptoms of hyperuricemia, and initiate treatment with urate-lowering drugs as appropriate. Tendon Rupture: Increased risk of tendon rupture or injury. Discontinue Nustendi at the first sign of tendon rupture. Avoid Nustendi in patients who have a history of tendon disorders or tendon rupture. Pregnancy and lactation. Adverse Reactions: Most common: upper respiratory tract infection, muscle spasms, hyperuricemia, back pain, abdominal pain or discomfort, bronchitis, pain in extremity, anemia, elevated liver enzymes, diarrhea, arthralgia, sinusitis, fatigue, and influenza. Others include tendon rupture, gout, benign prostatic hyperplasia, and flu-like illness. Drug Interactions: Simvastatin: Avoid concomitant use of Nustendi with simvastatin greater than 20 mg. Pravastatin: Avoid concomitant use of Nustendi with pravastatin greater than 40 mg. Cyclosporine: Monitor cyclosporine concentrations. Rhabdomyolysis: Monitor for muscle pain, tenderness, or weakness. Discontinue Nustendi if rhabdomyolysis is suspected in a patient receiving Nustendi and fenofibrate, consider alternative lipid-lowering therapy. Cholelithiasis: Administer Nustendi either at least 2 hours before or at least 4 hours after bile acid sequestrants.

Further information is available upon request.

Daiichi Sankyo Hong Kong Limited
Unit 1205, 12/F, Sino Plaza, 255-257 Gloucester Road, Causeway Bay, Hong Kong
Tel: (852) 2868 9079 I Fax: (852) 2801 4341

HK-DAI-NN-2308011 Approval date: Nov 2023

Section 3

Early LDL-C Control post ACS: Advancing Outcomes with PCSK9 inhibitors

梁逸倫
LEONG Iat Lon

BIOGRAPHY

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

前鏡湖醫院心臟科主治醫生 2018

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

臨床經歷

2000 澳門培正中學 高中畢業

2000 – 2005 廣州中山大學中山醫學院臨床醫學 本科

2006 – 2007 澳門科大醫院 全科醫生

2007 – 2012 澳門鏡湖醫院 急診及危急重症部 住院醫生

2012 – 2014 澳門鏡湖醫院 內科部 住院醫生

2014 – 2015 台灣台北榮民總醫院心內科 專科受訓醫生

2014 – 2015 專科指導教授 台灣台北醫學大學萬芳醫院心血管中心主任 陳保羅教授

2017 -2018 澳門鏡湖醫院內科部及心血管內科 住院總醫生

2019 澳門鏡湖醫院內科部及心血管內科 主治醫師

2020 澳門醫學專科學院內科部 心血管內科 院士 (全澳共 26 人)

2021 澳門科大醫院 特約專科醫生 心臟科

Medical

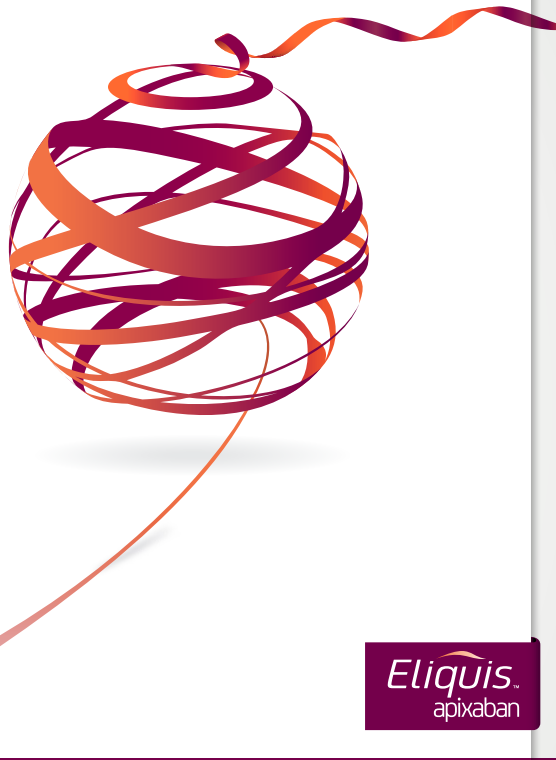
Chairperson: JIN Chun, FENG Xiu Hua, CHANG Tou

ELIQUIS™

THE SAFER CHOICE[1,2^]

Choose both efficacy and safety with ELIQUIS™

- Delivered 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[3†]



^ 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[3]

DVT deep vein thrombosis; NOAC, non-vitamin K antagonist oral anticoagulant; NVAF, nonvalvular atrial fibrillation; PE, pulmonary embolism; SE, systemic embolism; VKA, vitamin K antagonist; VTE, venous thromboembolism

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.** Agnelli G, et al. *N Engl J Med* 2013;369:799-808.

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PP-ELI-MAC-0012 SEP 2023

Scan the QR codes or type the URLs in your browser to find the full Prescribing Information of apixaban:

Apixaban (2.5 mg)
https://wwwpfi.sr/3Dg

Apixaban (5 mg)
https://www.pfi.sr/3DM

The QR code/ URL links to the latest version of Prescribing Information updated to Instituto para a Supervisão e Administração Farmacêutica (ISAF) in Macau.

Eliquis™ apixaban

Pfizer

Section 4

Modern Treatment of Intermediate High Risk PE

Esmond FONG

Dr. Esmond Fong (Hong Kong, China)
Associate Consultant
Queen Elizabeth Hospital, Hong Kong

BIOGRAPHY

Dr Esmond Fong obtained his medical degree from the University of Hong Kong. He completed his residency in internal medicine, fellowship in general and interventional cardiology at Queen Elizabeth Hospital, Hong Kong. He subsequently obtained his fellowship in peripheral intervention at Massachusetts General Hospital, Harvard Medical School in Boston, US. He is currently an Associate Consultant at Queen Elizabeth hospital. His clinical interests include cardiogenic shock, CHIP/ complex coronary interventions, Interventions in peripheral vascular disease, pulmonary embolism and venous diseases, heart failure management. He is currently the physician-in-charge for peripheral intervention and heart failure program at Queen Elizabeth Hospital.

Medical

Chairperson: CHONG Keng San, KONG Kuan Kei, CHEANG Teng

SIMDAX® 2.5mg/mL

levosimendan

心得適濃縮注射劑

健喬信元 SYNMOSA

ORION PHARMA

Cardioprotective inodilator: FIRST IN CLASS

Rapid and Sustained Benefits for the Failing Heart

INOTROPY

增加心肌收縮力

Cardiac Troponin C Sensitization
增加細胞內鈣離子與心肌的 troponin C 結合之敏感度

VASODILATION

擴張冠狀動脈與週邊血管

Smooth Muscle KATP channel Activation
打開位於血管平滑肌上對ATP敏感的鉀離子管道

SIMDAX® levosimendan (and its active metabolites)

迅速且持久

改善衰退的心臟功能

CARDIOPROTECTION

保護心肌細胞

Mitochondrial KATP channel Activation打開位於心肌細胞的粒腺體 (Mitochondria) 上對 ATP 敏感的鉀離子管道

Molecular targets	Mechanisms of action	Pharmacological Effects
增加細胞內鈣離子與心肌的 troponin C 結合之敏感度	Calcium sensitization	增加心肌收縮力
打開位於血管平滑肌上對 ATP 敏感的鉀離子管道	Hyper-polarization	擴張冠狀動脈與週邊血管
打開位於心肌細胞的粒腺體 (Mitochondria) 上對 ATP 敏感的鉀離子管道	Protection of mitochondria in ischemia-reperfusion	保護心肌細胞

Papp et al. Int J Cardiol 2011 e-pub

Section 4

Middle Meningeal Artery Embolization in Treatments of Chronic Subdural Hematoma

廖挺
LIAO Ting

BIOGRAPHY

專業資格：

澳門鏡湖醫院神經外科副主任顧問醫生

澳門醫學專科學院外科分科學院神經外科學部院士

社會職務：

澳門醫學專科學院會籍委員會委員

澳門醫學專科學院外科分科學院院務委員會委員

澳門醫學專科學院神經外科學部事務委員會委員

澳門外科學會理事長

澳門神經醫學會副會長

澳門臨床放射學會副會長

澳門腫瘤醫學會理事

Medical

Chairperson: CHONG Keng San, KONG Kuan Kei, CHEANG Teng

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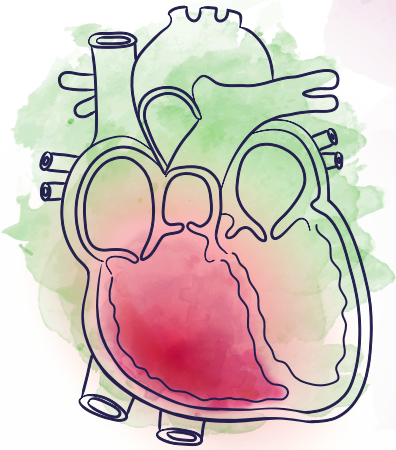
Breathe new air into **PAH**



23 Feb 2025 (Sun)

Lunch Symposium | **MGM Macau Hotel**

Join us for a lunch symposium where we will explore how to reimagine outcomes for pulmonary arterial hypertension (PAH) with the introduction of a first-in-class activin signalling inhibitor (ASI). Don't miss this opportunity to exchange knowledge and connect with healthcare professionals and peers who are committed to advancing patient care.

We look forward to your participation in this landmark event!

Agenda

Topic	Faculty
Breathe new air into PAH with a new ASI	Professor Edmund LAU
Panel discussion	Professor YAO Hua Professor Edmund LAU

For enquiries, please contact Helena Ling at helena.ling@merck.com

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HK-SOT-00020 JAN/2025

Section 4

EUS-guided Biliary Drainage

CHOI Kun Cheong

Specialist in Gastroenterology

CHCSJ hospital, Macau

BIOGRAPHY

Dr. CHOI Kun Cheong obtained his MBBS degree from Monash University Australia in year 2005. After completion of Internship Training in Australia in year 2006, he went back to Macau to continue his medical practice. He completed the Centro Hospitalar Conde de Sao Januario (CHCSJ) hospital General Internship training program in year 2011 and has been working in the public sector since then. He completed the Gastroenterology Training program in CHCSJ hospital in year 2021. Between the period of 1/07/2019 to 30/06/2020, he had successfully completed 1 year of Advanced Gastroenterology Fellowship training focusing on Advanced mucosal imaging and endoscopic interventions at Lyell McEwin Hospital in Australia under the supervision of Prof. Rajvinder Singh. Between the period of 18/09/2024 to 16/12/2024, he had completed 3 months of Endoscopic Ultrasound training at Chang Hai Hospital in Shanghai China under the supervision of Prof. Zhendong Jin. Currently he is working as a gastroenterology specialist in CHCSJ hospital.

Medical

Chairperson: CHONG Keng San, KONG Kuan Kei, CHEANG Teng

The Power of Protection

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EXPANDING PROTECTION

for a broad range of cardio-renal-metabolic conditions[1-5]

Renal

protection in CKD

eGFR decline **across the broadest range of CKD among SGLT2i**[#8,9]

CKD[9]

28% RRR

In kidney disease progression or CV death

HR=0.72; 95% CI: 0.64 to 0.82

NOW APPROVED FOR CKD[*1]

Cardiac

protection in HF across LVEF spectrum[6,7]

HFrEF[6]

25% RRR

In CV death or HHF

HR=0.75; 95% CI: 0.65 to 0.86

HFpEF[7]

21% RRR

In CV death or HHF

HR=0.79; 95% CI: 0.69 to 0.90

Metabolic

control with CV protection[10,11]

T2DM[10]

38% RRR

In CV death

HR=0.62; 95% CI: 0.49 to 0.77

The OAD reducing CV death[^10]

[#] In EMPA-KIDNEY trial, Jardiance® demonstrated to effectively slow eGFR decline in CKD patients with eGFR <30mL/min/1.73m², eGFR ≥30 to <45mL/min/1.73m², and eGFR ≥45mL/min/1.73m², and in CKD patients with eGFR ≥20 to <45mL/min/1.73m² across the spectrum of uACR

[*] Jardiance® 10mg is indicated to reduce the risk of kidney disease progression in adults with CKD (CKD Stages 2 and 3A with uACR ≥30 mg/g, or CKD Stages 3B, 4 and 5 irrespective of uACR)

[^] In T2DM patients with established CVD

Abbreviations: CKD: Chronic kidney disease; CI: Confidence interval; CV: Cardiovascular; CVD: Cardiovascular disease; eGFR: Estimated glomerular filtration rate; HF: Heart failure; HFpEF: Heart failure with preserved ejection fraction; HFrEF: Heart failure with reduced ejection fraction; HHF: Hospitalisation for heart failure; HR: Hazard ratio; LVEF: Left ventricular ejection fraction; OAD: Oral antidiabetic drug; RRR: Relative risk reduction; SGLT2i: Sodium-glucose cotransporter-2 inhibitor; T2DM: Type 2 diabetes mellitus; uACR: Urine albumin-creatinine ratio

References: 1. Jardiance® (Empagliflozin) Macau Prescribing Information. Boehringer Ingelheim; version 2024. **2.** Okoshiy S, et al. Can Empagliflozin be a Candidate for the Role of a Universal Cardio- and Nephroprotective Drug in Chronic Heart Failure without Diabetes Mellitus?. *Nephrol Dial Transplant.* 2020; 35(Supplement 3): P0965. **3.** Shi Z, et al. Comparative Efficacy of Dapagliflozin and Empagliflozin of a Fixed Dose in Heart Failure: A Network Meta-Analysis. *Front Cardiovasc Med.* 2022;9:869272. **4.** Sharaf El Din UAA, et al. Sodium-Glucose Cotransporter 2 Inhibitors as the First Universal Treatment of Chronic Kidney Disease. *Nefrologia (Engl Ed).* 2021;S0211-6995(21)00143-0:5. **5.** Pitalkowski RA, et al. SGLT2 Inhibitors for Type 2 Diabetes Mellitus Treatment. *Fed Pract.* 2015;32(Suppl 1):8S-15S. **6.** Packer M, et al. Cardiovascular and Renal Outcomes with Empagliflozin in Heart Failure. *N Engl J Med.* 2020;383(15):1413-1424. **7.** Anker SD, et al. Empagliflozin in Heart Failure with a Preserved Ejection Fraction. *N Engl J Med.* 2021;385(16):1451-1461. **8.** Fernández-Fernández B, et al. EMPA-KIDNEY: expanding the range of kidney protection by SGLT2 inhibitors. *Clin Kidney J.* 2023;16(8):1187-1199. **9.** Herrington WG, et al. Empagliflozin in Patients with Chronic Kidney Disease. *N Engl J Med.* 2023;388(2):117-127. **10.** Zinman B, et al. EMPA-REG OUTCOME Investigators. Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes. *N Engl J Med.* 2015;373(22):2117-28. **11.** Rosiin M, et al. Safety, Tolerability and Effects on Cardiometabolic Risk Factors of Empagliflozin Monotherapy in Drug-Naive Patients with Type 2 Diabetes: A Double-Blind Extension of a Phase III Randomized Controlled Trial. *Cardiovasc Diabetol.* 2015;14:154.

Abbreviated Prescribing Information JARDIANCE® (eh JARD-EE)

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 glucoselowering 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 heart failure independent of left ventricular ejection fraction, as an adjunct to standard of care therapy. Jardiance is indicated to reduce the risk of kidney disease progression in adults with chronic kidney disease. **Dosage and administration: Type 2 diabetes mellitus:** 10 mg once daily. In patients tolerating 10 mg once daily with an eGFR ≥ 20 mL/min/1.73m² and requiring additional glycaemic control, the dose can be increased to 25 mg once daily. Can be taken with or without food. **Heart Failure:** 10 mg once daily. Can be taken with or without food. **Chronic kidney disease:** 10 mg once daily. Can be taken with or without food. For patients with renal impairment, 10 mg can be used regardless of renal function. However, due to limited experience, it is not recommended to initiate treatment with JARDIANCE in patients with an eGFR <20mL/min/1.73m2 or on dialysis. No dose adjustment is required for patients with hepatic impairment, or for elderly patients. **Contraindication:** Hypersensitivity to empagliflozin or any of the excipients. **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. Cases of ketoacidosis have also been reported in patients without diabetes mellitus who were treated with Jardiance. 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. Not recommended for use when eGFR < 20 mL/min/1.73m² or on dialysis. Discontinue in cases of recurrent UTI. Due to a risk of modest decrease in blood pressure, consider temporarily discontinuing in patients for whom an osmotic diuresis due to empagliflozin may be a concern. Not recommended during the second and third trimesters of pregnancy. Discontinue as soon as pregnancy is detected. Not recommended during breast-feeding. Safety and effectiveness in children under 18 years of age have not been established. Initiation for treatment of type 2 diabetes mellitus is not recommended in patients aged 85 years and older due to limited therapeutic experience. 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 hypoglycaemia when used in combination with JARDIANCE. Empagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. Serum concentration of Lithium should be monitored more frequently after empagliflozin initiation and dose changes. **Adverse reaction:** Hypoglycaemia (depends on type of background therapy of patients); Urinary tract infection, vaginal moniliasis, vulvovaginitis, balanitis and other genital infection; Increased urination, dysuria; Constipation; Pruritus; Volume depletion; Thirst; Glomerular filtration rate decreased, blood creatinine increased, haematocrit increased, serum lipids increased. Postmarketing experience: Ketoacidosis, pyelonephritis, urosepsis, necrotising fasciitis of the perineum (Fournier's gangrene), allergic skin reaction, angioedema, phimosis. **Storage condition:** Please refer to outer packaging for special precautions for storage. **Note:** Before prescribing, please consult full prescribing information.

PC-HK-101440 (Sept 2024)

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Section 1

The Application of Bedside Ultrasonography in Nursing

陳永強
CHAN Wing Keung, David

BIOGRAPHY

陳永強，博士，教授，香港危重病護理專科學院(HKCCCN) - ICU 院士，現任香港聖方濟各大學健康科學院教授」；曾先後擔任香港理工大學(HKPU) 護理學院高級臨床講師，香港威爾斯親王醫院(PWH) ICU臨床護理專家(CNS)。

在行業資質方面，先後獲取澳大利亞危重病護理學院"高級危重病護理(ACCN)"課程導師，香港醫學專科學院(HKJC- ILCM)"高級呼吸機(ASTiM) "' `醫學模擬( CSEC)" "創 傷 化妝( MMM )"等課程導師， 美國心臟協會( AHA)"基礎生命支援 ( BLS)" "高 級 心 臟生命支援( ACLS)" 等課程 TC 主任導師，美國 EMT 國家學院( NAEMT)` `災 害應對 (AHDR)" "院前創 傷 生命支援(PHTLS) " "高級醫療生命支援 (AMLS)"等 課 程 導 師，英國(TQUK)" 戰 術 緊急醫療支持(TEMS)"課程導師， 香港心理衛生會(MHAHK)"心理急 救"課程 導 師。

在學術任職方面，現擔任中華護理學會重症監護委會員副主任委員、中國災害救援協會委員、香港護理學院(CNHK) 教育委員會主席、香港危重病護理專科學院(HKCCCN) 教育委員會委員，兼任澳門科技大學護理學院講師。

Nursing

Chairperson: CHUI Sze Ling Celine, LAM Wing Kuen William, TAM Hon Lon Alan

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Section 1

Sharing the Establishment of Chest Pain Centre in Hong Kong: Nursing Perspective

周美儀
CHAU Mei Yi

BIOGRAPHY

周美儀姑娘，現在服務於香港醫院管理局其下的醫院內工作。周姑娘在心臟科工作已經有廿十多年時間。在不同工作崗位擔任過護理，教學及管理工作，如心臟加護病房，心導管室，日間心臟護理部門等……累積了相關的知識和經驗。其間亦在進修過程中取得相關學位和專科資格，使其工作中可以將知識運用在部門發展和同事培訓。她現在是-位顧問護師。

在心臟科的護理工作需要不斷地去理解和吸收日新月異的知識, 近年亦有很多治療心臟衰竭的藥物和儀器出現，目的是希望這類病人的死亡率或再次入院的比率降低、病人的生活質素有改善。

Nursing

Chairperson: CHUI Sze Ling Celine, LAM Wing Kuen William, TAM Hon Lon Alan

metformin hydrochloride

Glucophage® XR

Concor®

Bisoprolol fumarate

MERCK

Mortality reduction

- **Concor®:** Reduce 34% in CHF patients[1]
- **Glucophage® XR:** Reduce 36% in overweight patients with newly diagnosed diabetes[2]

Indications along the continuum

- **Concor®:** HTN – CAD – CHF[3]
- **Glucophage® XR:** Prediabetes (unique) - Diabetes[4]

Improve patient adherence

- **Concor®:** High beta-1 selective with predictable outcome and minimal side effects[5-10]
- **Glucophage® XR:** Gelshield diffusion technology (unique) to reduce GI upset[11-12]

CAD: coronary artery disease, CHF: chronic heart failure, HTN: hypertension, GI: Gastrointestinal

References: 1. CIBIS-II Investigators and Committees (1999) The Lancet;353:9-13; 2. UK Prospective Diabetes Study (UKPDS) Group (1998) Lancet 352(9131):854-65; 3. Concor HK Prescribing Information. Approved Jul 2016; 4. Glucophage XR Prescribing Information Version: Jun 2018; 5. Dorow P, et al. (1986) Eur J Clin Pharmacol, 31, 143-147; 6. Chatterjee SS (1986) J Cardiovasc Pharmacol 8(11):74–77; 7. Asmar RG, Kerihuel JC, Girerd XJ et al., (1991), Am J Cardiol, 68 (1), 61-64; 8. Fogari R, et al. (1990.) Cardiovasc Pharmacol, 16 Suppl 5, S76-80; 9. Janka HU, et al. (1986), J Cardiovasc Pharmacol, 8 Suppl 11, S96- 99; 10. Broekman CP, et al. (1992), J Sex Marital Ther, 18(4), 325-331; 11. Timmins P. (2005) Clin Pharmacokinet 44:721-9; 12. Blonde et al. (2004) Curr Med Res Opin 20:565-72.

Products: Concor 2.5mg, Concor 5mg film-coated tablets for oral use containing 2.5mg & 5mg bisoprolol fumarate, respectively. Indications: 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. 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 for 2nd week, 3.75 for 3rd week, 5 4th to 7th week, 7.5 for 8th to 11th week, 10mg for 12th week and beyond, once daily) 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, uptitration 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: hypertension or angina pectoris and accompanying heart failure; bronchospasm (bronchial asthma, obstructive airways disease; diabetes mellitus; symptoms of hypoglycemia can be masked; strict fasting; ongoing desensitization therapy; first degree AV block; Prinzmetal's angina; peripheral arterial occlusive disease; phaeochromocytoma. Patients with psoriasis or with a history of psoriasis. Symptoms of thyrotoxicosis may be masked. In patients undergoing general anesthesia, the anesthetist 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. Treatment of stable chronic heart failure with bisoprolol has to be initiated with a special titration phase. Especially in patients with coronary heart disease, the cessation of therapy with bisoprolol must not be done abruptly unless clearly indicated. There is no therapeutic experience in Concor in patients with NYHA class II heart failure, 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: During pregnancy Concor is only recommended following careful assessment of benefit-to-risk ratio by the doctor. Use of bisoprolol not recommended during breastfeeding. 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, depression, sleep disorders, asthenia, orthostatic hypotension, in patients with hypertension or angina pectoris: worsening of pre-existing heart failure, bradycardia. Rare: increased triglycerides, increased liver enzymes (ALAT, ASAT), syncope, reduced tear flow, hearing disorders, allergic rhinitis, hypersensitivity reactions such as itching, flush, rash; hepatitis, erectile dysfunction, 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. Validity Code: February 2019

Glucophage® XR 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-00035 APR2023

Section 1

Evidence Based Practice in Nursing

CHEUNG Shuk Ting, Denise

BIOGRAPHY

Dr Denise Cheung is an Assistant Professor at the School of Nursing at the University of Hong Kong. She is a registered nurse with 10+ years of teaching experience mainly on health education and promotion and nursing research. Her research focuses on cancer survivorship. The key themes of her research work include: i) examining the effects of complementary and alternative medicine (e.g., qigong, acupressure) and physical activity on physical and psychological sequelae of cancer, ii) designing theoretically-driven physical activity promotion interventions in cancer survivors, and iii) exploring the potential of translating evidence related to physical activity to practice. She has considerable experience of developing and evaluating evidence-based interventions using mixed-method research designs.

Nursing

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IT COULD ONLY BE REPATHA®

For your patients with established ASCVD

CHOOSE **PROVEN OUTCOMES**

Repatha® added to a statin was **proven to reduce the risk of CV events** in the FOURIER study[1]

Composite CV event (key secondary endpoint) risk reduced by

20%
With Repatha® + statin vs. statin alone[2]
(HR=0.80; 95% CI: 0.73-0.88; *p*<0.001)

MI
27% RRR (HR=0.73; 95% CI: 0.65-0.82; *p*<0.001)

CORONARY REVASCULARIZATION
22% RRR (HR=0.78; 95% CI: 0.71-0.86; *p*<0.001)

STROKE
21% RRR (HR=0.79; 95% CI: 0.66-0.95; *p*=0.01)

CHOOSE **AN ESTABLISHED SAFETY PROFILE**

Repatha® demonstrated **favorable long-term** safety in the 5-year OSLER-1 study[2]

The rates of AEs were **stable and consistent** over the 5-year treatment

Safety profile **comparable** to placebo

No neutralizing antibodies were detected **in 5 years**

CHOOSE **AT-HOME ADMINISTRATION**

- **Simple** dosing every **2 or 4 weeks**[3]
- **Comfortable** self-injection with Repatha® SureClick® Autoinjector[3]
- **No titration** needed[3]

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 or higher and/or non-HDL-C 2.6 mmol/L or higher 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. 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. 1,255 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: AE=adverse event; ASCVD=atherosclerotic cardiovascular disease; 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.
References: 1. Sabatine MS, et al. Evolocumab and clinical outcomes in patients with cardiovascular disease. N Engl J Med. 2017;376:1713-1722. **2.** Koren MJ, et al. Long-term efficacy and safety of evolocumab in patients with hypercholesterolemia. J Am Coll Cardiol. 2019;74(17):2132-2146. **3.** Repatha® Hong Kong Full Prescribing Information. Jun 2022.

Repatha® (Evolocumab) Abbreviated Prescribing Information
PRESENTATION: Solution for injection, pre-filled autoinjector 140 mg/mL. **INDICATIONS:** Adult with primary hypercholesterolaemia (heterozygous familial and non familial) or mixed dyslipidaemia, and paediatric patients ≥10 years with heterozygous familial hypercholesterolaemia: As an adjunct to diet: In combination with a statin or statin with other lipid-lowering therapies in 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 patients who are statin-intolerant or for whom statin is contraindicated. Homozygous familial hypercholesterolaemia: in combination with other lipid-lowering therapies in adults and paediatric patients ≥10 years. Established atherosclerotic cardiovascular disease (myocardial infarction, stroke or peripheral arterial disease): in adults 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, fed, 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, headache, nausea, back pain, arthralgia, myalgia, injection site reactions such as bruising, erythema, haemorrhage, pain, swelling. **Please read full prescribing information prior to administration (available upon request). HKREPPIOS.**

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MAC-145-0254-80001 SEP 2024

Section 1

Overview of Hong Kong Cardiac Catherization Laboratory service: Opportunities and Challenges

陳健禧
CHAN Kin Hei, Anthony

BIOGRAPHY

香港心臟科專科護士

陳健禧先生為心臟科專科護士，現職在香港大學護理學院擔任講師。曾在公立和私家醫院任職，擁有豐富的心導管室經驗。

Nursing

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Add protection with Verquvo® vericiguat when they need it the most

Verquvo® is indicated for the treatment of symptomatic chronic heart failure in adult patients with reduced ejection fraction who are stablised* after a recent decompensation event requiring IV therapy.[1]

A worsening HF event is defined as a heart failure hospitalization or outpatient IV diuretic use for heart failure.[2]

† Following a worsening HF event.

* Not having administration of any intravenous treatment within 24 hours, and/or systolic blood pressure (SBP) <100 mmHg or symptomatic hypotension[2]

Study design: VICTORIA is a phase 3, randomized, double-blind, placebo-controlled trial involved 5050 patients that evaluated the efficacy and safety of Verquvo® (target dose, 10 mg once daily) versus placebo in patients with symptomatic chronic HF and an ejection fraction of <45%, in addition to guideline-based medical therapy. Patients also had to have worsening heart failure.[2,3] The primary outcome was a composite of death from CV causes or first hospitalization for HF.[2,3] The median follow-up period was 10.8 months.[2]

Verquvo® 2.5 / 5 / 10 mg film-coated tablets
Abbreviated Prescribing Information
(Please refer to the full prescribing information before prescribing)
Indication for Use: Treatment of symptomatic chronic heart failure in adult patients with reduced ejection fraction who are stabilised after a recent decompensation event requiring IV therapy. **Composition:** Active ingredient: 2.5 mg/5 mg/10 mg vericiguat. Excipients: microcrystalline cellulose, croscarmellose sodium, hypromellose 2910, lactose monohydrate, magnesium stearate, sodium laurilsulfate, talc, titanium dioxide (E 171), iron oxide red (E 172) (Verquvo® 5 mg only), iron oxide yellow (E 172) (Verquvo® 10 mg only). **Posology and Method of Administration:** For oral use and should be taken with food. Vericiguat is administered in conjunction with other heart failure therapies after stabilisation. The recommended starting dose is 2.5 mg vericiguat once daily, and should be doubled approximately every 2 weeks to reach the target maintenance dose of 10 mg once daily, as tolerated by the patient. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients; Concomitant use of other soluble guanylate cyclase (sGC) stimulators, such as riociguat. **Warnings and Precautions:** ***Symptomatic hypotension:*** Vericiguat may cause symptomatic hypotension. Patients with SBP <100 mmHg or symptomatic hypotension at treatment initiation were not studied. The potential for symptomatic hypotension should be considered in patients with hypovolaemia, severe left ventricular outflow obstruction, resting hypotension, autonomic dysfunction, history of hypotension, or concomitant treatment with antihypertensives or organic nitrates. If patients experience tolerability issues (symptomatic hypotension or SBP <90 mmHg), temporary down-titration or discontinuation of vericiguat is recommended. Concomitant use of vericiguat and PDE5 inhibitors has not been studied in patients with heart failure and is therefore not recommended due to the potential increased risk for symptomatic hypotension; ***Renal impairment:*** treatment with vericiguat is not recommended in patients with eGFR <15 mL/min/1.73 m^2 at treatment initiation or on dialysis; ***Hepatic impairment:*** treatment with vericiguat is not recommended in patients with severe hepatic impairment; ***Excipients***: This medicinal product contains lactose and sodium (<1 mmol sodium per tablet). **Adverse effects:** Very common (≥1/10): hypotension; *Common* (≥1/100 to <1/10): anaemia, dizziness, headache, nausea, dyspepsia, vomiting, gastro-oesophageal reflux disease. For *uncommon and rare adverse reactions*, please refer to the full prescribing information (Dec 2021). (MA-M_VER-HK-0052-1 Aug 2022)

References
1. Verquvo® 2.5 / 5 / 10mg film-coated tablets Hong Kong prescribing information (Dec 2021). 2. Armstrong PW, et al. NEJM 2020;382(20):1883–1893. 3. Armstrong PW, et al. JACC Heart Fail. 2018;6(2):96-104. 4. Lam CSP, et al. J Am Heart Assoc. 2021 Nov 16;10(22):e021094.

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Footnotes:
ARR: absolute risk reduction. CV: cardiovascular. HF: heart failure. HFH: heart failure hospitalization. IV: intravenous. MOA: mechanism of action. NO-sGC-cGMP: nitric oxide-soluble guanylate cyclase-cyclic guanosine monophosphate. NNT: number needed to treat.

PP-VER-HK-0041-1 032023

Section 2

解鎖內地心血管介入護理密碼

馬瑛
MA Ying

BIOGRAPHY

珠海市人民醫院醫療集團 介入手術室 護士長

職稱：副主任護師

學歷/學位：碩士研究生

擅長領域：介入手術配合、介入復合手術配合、護理管理

學術成就：在介入手術室工作14年，對介入手術配合、介入復合手術配合等介入專科領域具有豐富的臨床經驗。 主要擅長腫瘤介入護理、周圍血管介入護理、綜合介入護理、心血管介入護理、神經介入護理等。 參與醫院內教學培訓工作醫技片區的教學組長，發表論文4篇，專利11項。 參與護理團體標準及書籍編著有多項，珠海市科研課題1項。

學會任職：

廣東省護士協會第一屆介入護士分會 委員

廣東省護理學會第九屆理事會心血管介入護理專業委員會 常委

廣東省醫學會介入醫學分會第一屆委員會護理學組 秘書

廣東省護士協會手術護理分會介入手術護理學組 副組長

廣東省護理學會第九屆理事會類比教育專業委員會 委員

珠海市香洲區第十屆人民代表大會 代表

珠海市護理學會介入護理專業委員會 常委兼秘書

珠海市護士協會介入護士分會 常委兼秘書

珠海市護士協會影像醫學與介入護士分會 委員

國際血管聯盟中國分會護理專業委員會 委員

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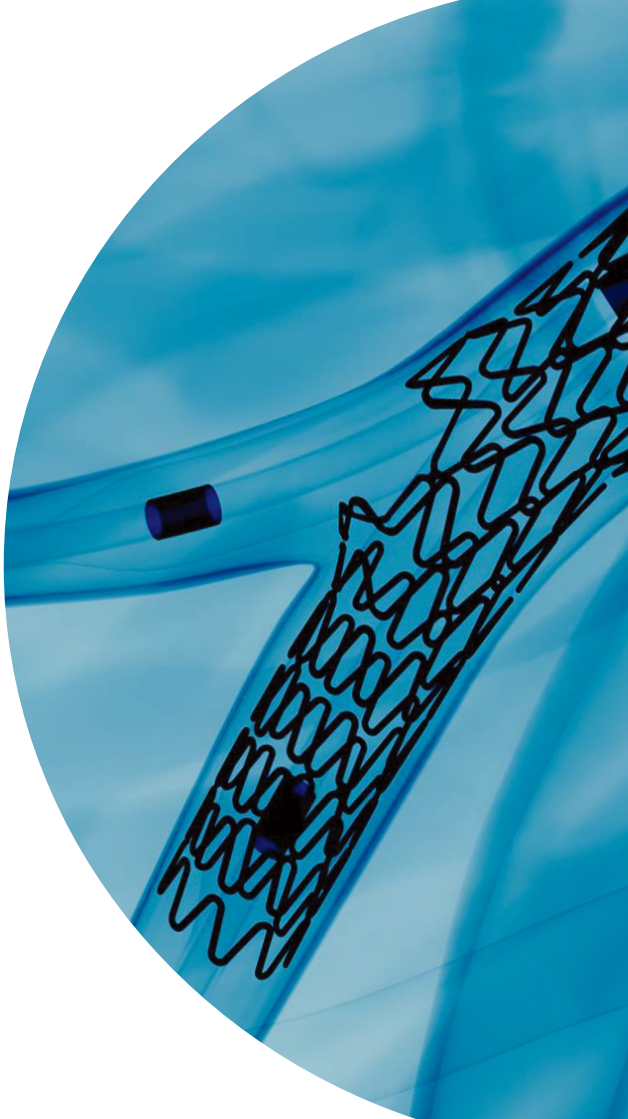

Section 2

專利創新構想引領介入護理發展新方向

鍾海
ZHONG Hai

BIOGRAPHY

碩士、主任護師 | 中山市人民醫院介入手術室護士長

擅長介入護理管理與各種介入手術護理配合; 發表和參與論文20餘篇、院級立項2項、中山市科研立項3項、國家級專利16項、參與著作7本，專家共識6份，團體標準3份; 曾獲廣東省護理學會第二屆十佳護理科技工作者獎、第三屆十佳才藝能手獎。

學術任職：

中山市護理學會介入護理專業委員會主任委員

中山市護理學會男護士專業委員會副主任委員

南方介入護理聯盟副主席

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《中外醫療》雜誌編委會成員

廣東省護理學會介入專科護士培訓基地（中山）負責人

廣東省護士協會介入專科護士培訓基地（中山）負責人

心血管護理及技術培訓基地介入（中山）負責人

中山市護理學會介入專科護士培訓基地負責人

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CORAIVA05i APR 2024

Section 2

Nursing Care for Patients Receiving Interventional Cardiac Catheterisation

TAM Wai Keong, Benny

BIOGRAPHY

Mr. Tam is a specialist nurse of cardiology, started his nursing career at Kiang Wu Hospital in Macau. After graduation, he gained a specialty training in Cardiac thoracic surgery and Intensive care nursing at Singapore General Hospital. After returning to Macau, he started caring for cardiac surgery patients.

Mr. Tam has extensive nursing experience in Cardiac and Thoracic ICU, CCU and Cardiac Catheterization. He has 18 years of relevant work experience. He is currently a CCU and Cardiac Catheterization Care nurse at Conde S. januario Hospital. He is responsible for nursing care, patient education, nursing management, clinical teaching as instructors, and SOP construction in the clinical field of cardiology.

Nursing

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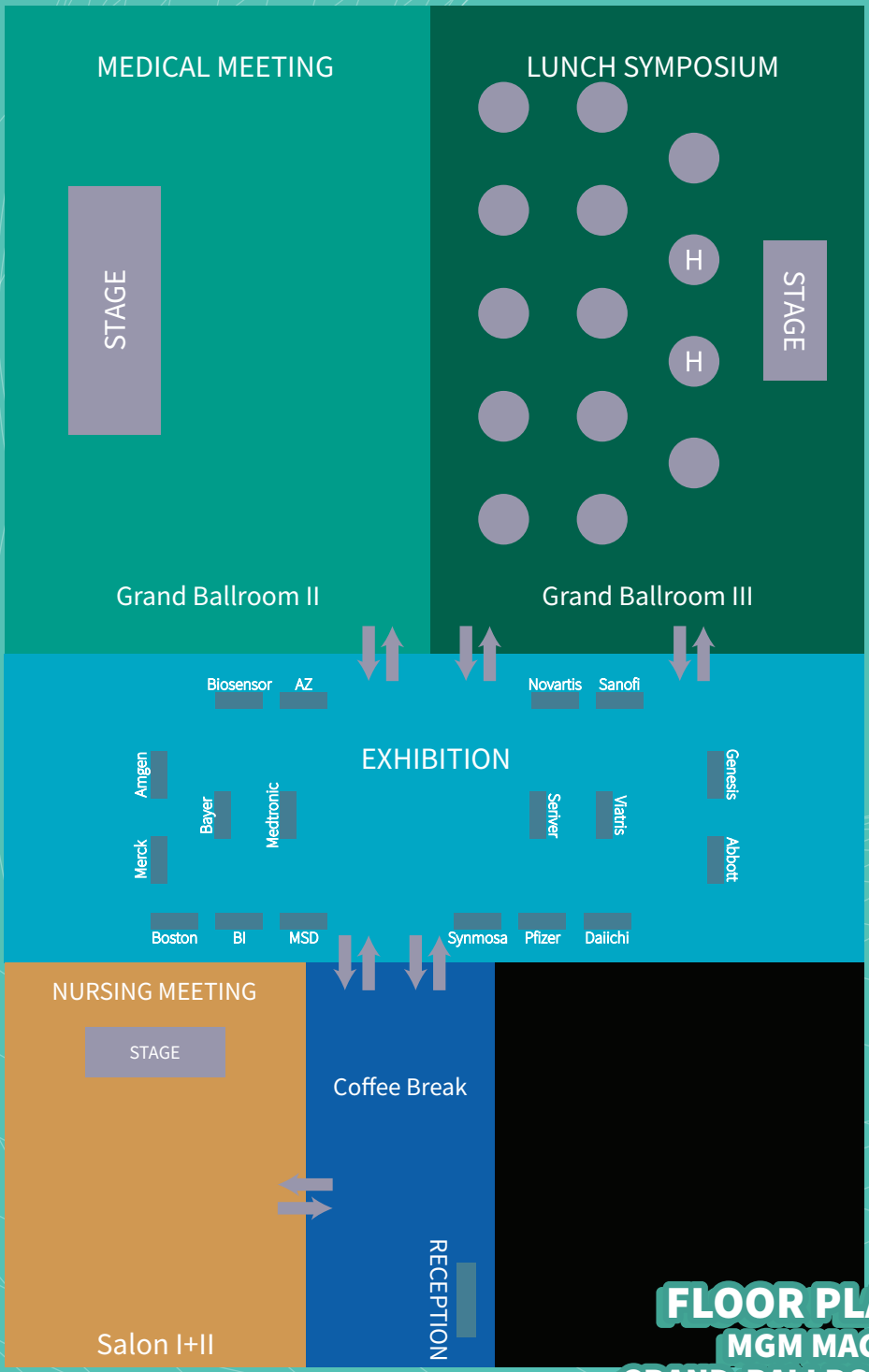
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EXHIBITION
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Viatris
Genesis
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