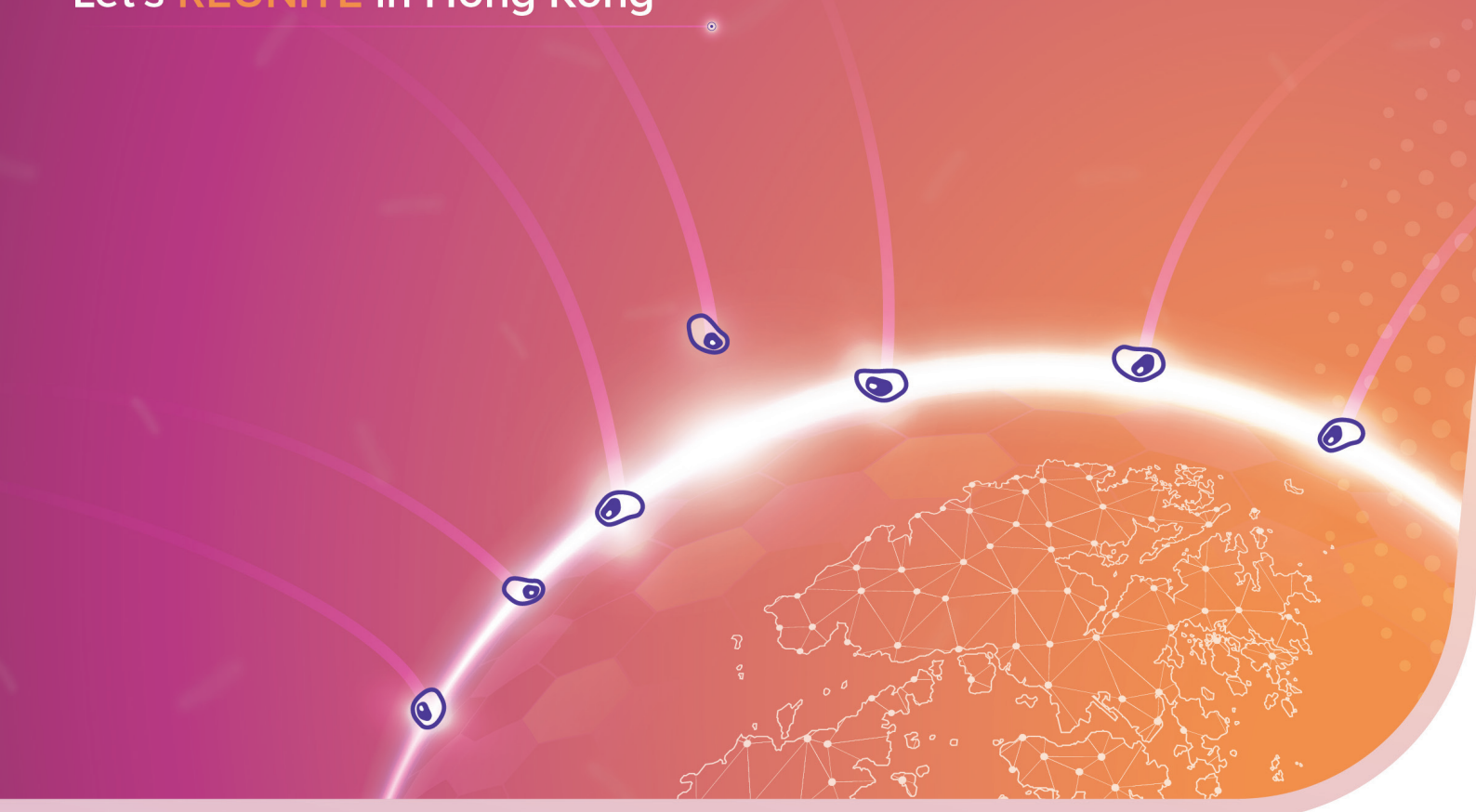
APS 2023
Hong Kong

Spring 2023

# Inaugural Advanced Asia Pacific Society for Immunodeficiencies IEI School

April 22-23, 2023

Let's REUNITE in Hong Kong



APSID
Tolerance to Balance... ...Creativity from Diversity

HKU Med School of Clinical Medicine
Department of Paediatrics & Adolescent Medicine
香港大學兒童及青少年科學系

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# Welcome Message

Dear friends,

The world has gone through 3 years of the COVID-19 pandemic, and many of you spearheaded your respective country, region, or hospital's COVID-19 response, caring for patients and conducting research to better understand the best ways to overcome this pandemic.

Now that the pandemic's impact on humanity begins to come to an end, with our clinical and research activities adapting to a new norm, this is the best time for the sisters and brothers of APSID to reunite, reconnect, and pursue our passion for inborn errors of immunity (IEI). As APSID was founded in Hong Kong in 2016, I could think of no better place for us to reunite during the initial post-pandemic period.

Seven years have passed since the conception of APSID, and there has been tremendous progress in IEI care and research in Asia. There are now more and more advanced research groups in Asia in the field of IEI, with many novel IEI genes discovered, new treatment strategies pioneered, and many collaborative studies published. This will be APSID's first Advanced IEI School, which aims to allow participants to share their clinical expertise, update on research progress, and train a new generation of IEI clinician-scientists. I encourage junior members from every clinical and academic IEI centre to submit their most difficult cases and novel research findings to this Inaugural Advanced APSID IEI School in Hong Kong, come gather to gain exposure for their budding research, and spark new opportunities for collaboration.

## Let's reunite in Hong Kong!

**Prof Yu Lung Lau**
APSID Founding President and School Chair
The University of Hong Kong, Hong Kong

# Program

## Day 0 April 21, 2023

**18:00 Welcome Dinner**

Venue: The Helena May
For student presenters and faculty

Dress code: smart casual

## Day 1 April 22, 2023 Clinical Day

**09:00 Atopy**

Clinical cases moderated by Stuart Turvey and Jaime Rosa Duque featuring oral abstracts

Speaker
Stuart Turvey
BC Children's Hospital, Canada

| | | Presenter | Chair |
|---|---|---|---|
| 09:15 | Human Germline Heterozygous Gain-of-Function STAT6 Variants Cause Severe Allergic Disease | Mehul Sharma, Vancouver, Canada | Jaime Rosa Duque |
| 09:25 | A case of severe eosinophilic gastroenteritis caused by a novel STAT6 gain-of-function variant | Fumiaki Sakura, Hiroshima, Japan | Jaime Rosa Duque |
| 09:35 | A refractory pediatric case of eosinophilic granulomatosis with polyangiitis due to a novel NFKB2 mutation | Lin Li, Sichuan, China | Stuart Turvey |

**10:00 Autoinflammation**

Clinical cases moderated by Mingsheng Ma and Vignesh Pandiarajan featuring oral abstracts

Speaker
Mingsheng Ma
Peking Union Medical College Hospital

| | | Presenter | Chair |
|---|---|---|---|
| 10:15 | Clinical heterogeneity of NLRP12-associated autoinflammatory diseases | Yue Li, Beijing, China | Vignesh Pandiarajan |
| 10:25 | The crossroads between Immunodeficiency and autoinflammation | Sohilla Lotfy, Cairo, Egypt | Mingsheng Ma |
| 10:35 | Cleavage-resistant RIPK1-induced autoinflammatory syndrome | Harikrishnan Gangadharan, Kerala, India | Vignesh Pandiarajan |

**11:00 Poster Walk**

**12:00 Presented by Pfizer: Viral and Mycobacterial Infections**

Clinical cases moderated by Huawei Mao and Pamela Lee featuring oral abstracts

Speaker
Huawei Mao
Beijing Children's Hospital, China

| | | Presenter | Chair |
|---|---|---|---|
| 12:15 | Multiple immune defects in two patients with novel DOCK2 mutations result in recurrent multiple infection including live attenuated virus vaccine | Wenhui Li, Chongqing, China | Huawei Mao |
| 12:25 | Long road to recovery of one IFNGR1 deficiency case: from head to calf, from BCG to NTM | Wenjing Zhang, Beijing, China | Pamela Lee |
| 12:35 | Recurrent non-tubercular mycobacterial infection in unusual area in a combined immunodeficiency | Harsha Sonak, Vellore, India | Huawei Mao |

**13:00 Lunch Workshop: Immunological Diagnostics**

Chaired by Wenwei Tu and Zarina Zainudeen

Speaker
Melanie Wong
Children's Hospital at Westmead, Australia

Speaker
Brahim Belaid
Beni Messous Hospital Center, Algeria

## 13:50 Presented by CSL Behring: Common Variable Immunodeficiency

Clinical cases moderated
by Klaus Warnatz and Hans Ochs
featuring oral abstracts

Speaker
Klaus Warnatz (Pre-recorded talk)
Medical Center – University of Freiburg, Germany

| | | Presenter | Chair |
|---|---|---|---|
| 14:05 | Abatacept with rapamycin significantly improved pulmonary fibrosis in a patient with LRBA deficiency | Wenli He<br>Chongqing, China | Hans Ochs |
| 14:15 | CMV retinitis in a patient with NFKB2 mutation | Haijuan Xiao<br>Beijing, China | Hans Ochs |
| 14:25 | Tubercular meningitis in a child with novel LRBA deficiency | Ajeitha Loganathan<br>Coimbatre, India | Hans Ochs |

## 14:50 Presented by MSD: Bacterial Infections

Clinical cases moderated
by Hirokazu Kanegane and Melanie Wong
featuring oral abstracts

Speaker
Hirokazu Kanegane
Tokyo Medical and Dental University Hospital, Japan

| | | Presenter | Chair |
|---|---|---|---|
| 15:05 | Infections due to Burkholderia Sp. in children with chronic granulomatous disease | Munish Arora<br>Chandigarh, India | Melanie Wong |
| 15:15 | Lung surgery in STAT3 loss-of-function mutation: is it advisable? | Mahnaz Jamee<br>Tehran, Iran | Hirokazu Kanegane |

## 15:40 Poster Walk

## 16:40 Fungal Infections

Clinical cases moderated
by Satoshi Okada and Jonie Santos-Ocampo
featuring oral abstracts

Speaker
Satoshi Okada
Hiroshima University Hospital, Japan

| | | Presenter | Chair |
|---|---|---|---|
| 16:55 | CARD9 c.820dup is a founder effect in East Asia | Dan Tomomasa<br>Tokyo, Japan | Satoshi Okada |
| 17:05 | Disseminated histoplasmosis in a Brazilian patient with G6PD deficiency caused by class I variant | Ranieri Salgado<br>Sao Paulo, Brazil | Satoshi Okada |
| 17:15 | Single cell transcriptome revealed different cellular and transcriptional signature in PBMCs from patients with STAT1 GOF/LOF mutations | Yuting Sun<br>Chongqing, China | Jonie Santos-Ocampo |

## 17:40 The 3rd Professor Yu Lung Lau Oration

**The Implementation of Newborn Screening for IEI in Brazil: The Perspective of a Developing Country**

Chaired by Surjit Singh

Speaker
Antonio Condino-Neto
University of Sao Paolo, Brazil

## 18:10 Faculty Dinner

Venue: FAM

For faculty and Platinum sponsors

# Program

## Day 2 April 23, 2023 Advanced Day

### 08:15 Keynote Lecture: History of IEI

Chaired by Yu Lung Lau

Speaker
Hans Ochs
Seattle Children's Hospital, USA

### 08:30 Keynote Lecture: History of IEI in China

Chaired by Yu Lung Lau

Speaker
Xiaodong Zhao
Second Affiliated Hospital of Chongqing Medical University, China

### 09:00 Registry

Chaired by Youjia Zhong
featuring oral abstracts

Speaker
Yae Jean Kim (Pre-recorded talk)
Samsung Medical Center, Korea

| | | Presenter | Chair |
|---|---|---|---|
| 09:15 | A multicenter cohort study of immune dysregulation disorders caused by ELF4 mutations in China | Gan Sun<br>Chongqing, China | Youjia Zhong |
| 09:25 | Prospective study on the efficacy and impact of Cascade Screening and Evaluation of HAE (CaSE-HAE) | Jane Wong<br>Hong Kong, China | Youjia Zhong |
| 09:35 | PID care in development: Everest ahead yet to be scaled | Dharmagat Bhattarai<br>Kathmandu, Nepal | Youjia Zhong |

**Panel discussion: What can APSID registry contribute to IEI research**

### 10:00 Novel Gene Discovery

Chaired by Stuart Turvey and Wanling Yang

Speaker
Tomohiro Morio
Tokyo Medical and Dental University Hospital, Japan

Speaker
Qing Zhou
Zhejiang University, China

Speaker
Yuxia Zhang
Guangzhou Children's and Women's Medical Center, China

**Panel discussion: How to discover novel IEI genes in Asian patients**

### 11:00 Poster Walk

### 12:00 Screening

Chaired by Huawei Mao
featuring oral abstracts

Speaker
Kohsuke Imai
National Defense Medical College Hospital, Japan

| | | Presenter | Chair |
|---|---|---|---|
| 12:15 | Newborn screening using TREC/KREC/RNase P triplex assay - the first pilot study in China | Lu Yang<br>Chongqing, China | Huawei Mao |
| 12:25 | Value of TREC levels in the diagnosis of PID in children | Van Anh Nguyen Thi<br>Hanoi, Vietnam | Kohsuke Imai |
| 12:35 | TREC and KREC in patients with CVID | Anit Kaur<br>Chandigarh, India | Kohsuke Imai |

**Panel discussion: Should we include KREC in newborn screening**

### 13:00 Lunch Workshop: Molecular Diagnostics

Chaired by Woei Kang Liew and
Antonio Condino-Neto

Speaker
Narissara Suratannon
King Chulalongkorn Memorial Hospital, Thailand

Speaker
Wanling Yang
University of Hong Kong, Hong Kong

## 13:50 Molecular Diagnostics

Chaired by Narissara Suratannon and Wanling Yang
featuring oral abstracts

| | | Presenter | Chair |
|---|---|---|---|
| 13:50 | A semi-automated variant ranking system based on ACMG pathogenecity interpretation guideline | Xingtian Yang<br>Hong Kong, China | Narissara Suratannon |
| 14:00 | Difficulties in targeted NGS for inborn errors of immunity | Madhubala Sharma<br>Chandigarh, India | Narissara Suratannon |
| 14:10 | The first compound heterozygous novel variants in CD55 in two siblings manifested as early-onset inflammatory bowel disease | Tharida Khongcharoensombat<br>Bangkok, Thailand | Wanling Yang |
| 14:20 | Novel variant in ORAI1, an inherited channelopathy, causing severe combined immunodeficiency, autoimmunity, enamel hypoplasia, and hypotonia. | Onnicha Chaiseksamphan<br>Bangkok, Thailand | Wanling Yang |

## 14:45 HSCT

Chaired by Wing Leung
featuring oral abstracts

Speaker
Andrew Gennery
NHS University hospital upon Tyne, UK

| | | Presenter | Chair |
|---|---|---|---|
| 15:00 | Stem cell transplantation for Wiskott-Aldrich syndrome | Le Nguyen Ngoc Quynh<br>Hanoi, Vietnam | Wing Leung |
| 15:10 | HSCT and vaccine related infections in children with Inborn Errors of Immunity | Suresh RD<br>Chennai, India | Wing Leung |
| 15:20 | Emerging spectrum of DOCK8 deficiency and challenges associated with HSCT | Kavitha Ganesan<br>Chennai, India | Andrew Gennery |

**Panel discussion: HSCT for primary immune dysregulation diseases**

## 15:45 Poster Walk

## 16:45 Gene therapy

Chaired by Godfrey Chan
featuring oral abstracts

Speaker
Thomas Whittaker (Pre-recorded talk)
Great Ormond Street Hospital, UK

| | | Presenter | Chair |
|---|---|---|---|
| 17:00 | Successful Preclinical Gene Therapy Study for X-SCID | Qiling Xu<br>Chongqing, China | Godfrey Chan |
| 17:10 | Gene editing of APDS | Anle Zeng<br>Chongqing, China | Godfrey Chan |

**Panel discussion: How to introduce gene and cellular therapy to Asia**

## 17:35 Presented by SINOVAC: COVID-19

Chaired by Satoshi Okada
featuring oral abstracts

Speaker
Yu Lung Lau
APSID Founding President and School Chair
The University of Hong Kong, Hong Kong

| | | Presenter | Chair |
|---|---|---|---|
| 17:50 | Immune dysregulation in Covid-19 associated mucormycosis | Manpreet Dhaliwal<br>Chandigarh, India | Satoshi Okada |
| 18:00 | A case with XLA died of meningoencephalitis caused by COVID-19 | Hung Tran<br>Hanoi, Vietnam | Yu Lung Lau |
| 18:10 | Convalescent Plasma Achieved SARS-CoV-2 Viral Clearance in a Patient With Severe Combined Immunodeficiency | Rongxin Dai<br>Chongqing, China | Satoshi Okada |

**Panel discussion: Should we give seasonal COVID boosters to IEI patients**

## 18:35 Closing Remarks and Awards

Presented by Yu Lung Lau and Surjit Singh

## 19:00 APSID EB Working Dinner

Venue: Nam Fong (For APSID EB)

# Poster Walk

Day 1 April 22, 2023 Clinical Day

## 11:00 Poster Walk

| | | Faculty |
|---|---|---|
| A | 4 abstracts by Bui, Chavoshzadeh, Wong and Yaakoubi | Stuart Turvey and Jaime Rosa Duque |
| B | 5 abstracts by Deng, Li, Mou and Xu | Qing Zhou and Melanie Wong |
| C | 4 abstracts by Kaneko, Lu, Nandakumar and Thangaraj | Mingsheng Ma and Kai Ning Cheong |
| D | 4 abstracts by Patra, Pilania and Wakatsuki | Yuxia Zhang and Vignesh Pandiarajan |
| E | 4 abstracts by Meiping, Nong, Shamsul Bahrain and Zheng | Yunfei An and Hans Ochs |

**Scan to see the abstracts**

## 15:40 Poster Walk

| | | Faculty |
|---|---|---|
| A | 4 abstracts by Baral, Hasan, Phan and Zainul Fadziruddin | Hans Ochs and Fatima Santos Ocampo |
| B | 4 abstracts by Chen, Shaly and Wang | Satoshi Okada and Antonio Condino Neto |
| C | 4 abstracts by Basu, Tang, Tyagi and Xing | Pamela Lee and Youjia Zhong |
| D | 4 abstracts by Alkady, Islam, Nadig and Zhang | Huawei Mao and Tomohiro Morio |
| E | 4 abstracts by Quiambao, Shafiei and Zheng | Brahim Belaid and Xiaodong Zhao |

**Scan to see the abstracts**

## 11:00 Poster Walk

| | | Faculty |
|---|---|---|
| A | 5 abstracts by Chan, Lai, Roy and Zainudeen | Yu Lung Lau and Vignesh Pandiarajan |
| B | 4 abstracts by Gao, Ghadimi, Loganathan and Nguyen | Brahim Belaid and Amit Rawat |
| C | 4 abstracts by Bhattarai, Lim, Sarmin and Yenigalla | Andrew Gennery and Kohsuke Imai |
| D | 5 abstracts by Chougule, Hou (Tang), Kim, Natarajan and Nguyen Thi | Surjit Singh and Yuxia Zhang |
| E | 5 abstracts by Cheong, Huang, Petrosyan, Suksai and Wong | Woei Kang Liew and Fatima Santos Ocampo |

**Scan to see the abstracts**

## 15:45 Poster Walk

| | | Faculty |
|---|---|---|
| A | 4 abstracts by Pilania, L. Shu and Z. Shu (Gu) | Wanling Yang and Youjia Zhong |
| B | 5 abstracts by Banday, Gu, Li and Ng | Hans Ochs and Yu Lung Lau |
| C | 4 abstracts by DAS, Ganesan, Guendulain and RD | Woei Kang Liew and Amit Rawat |
| D | 4 abstracts by Hà, Jamee, Kim and Loganathan | Hirokazu Kanegane and Yunfei An |
| E | 4 abstracts by Baek, Gao, Liang and Sharma | Narissara Suratannon and Zarina Zainudeen |

**Scan to see the abstracts**

# Faculty

## Amit Rawat

PGIMER Chandigarh, India

Professor Amit Rawat is a leading expert in Pediatric Allergy and Immunology and currently serves as a professor at the Allergy Immunology Unit, Department of Pediatrics, at the Postgraduate Institute of Medical Education and Research (PGIMER) in Chandigarh, India. His research interests encompass genetic defects in antibody deficiencies, complement deficiencies, and monogenic forms of systemic lupus erythematosus. Prof. Rawat also investigates autoimmunity in chronic granulomatous disease, contributing significantly to the advancement of understanding and treatment of pediatric immune disorders.

## Andrew Gennery

NHS University hospital upon Tyne, UK

Professor Andrew Gennery is a distinguished Paediatric Immunologist specializing in Hematopoietic Stem Cell Transplantation (HSCT) at Newcastle University's Faculty of Medical Sciences in the UK. In addition to his academic role, he serves as an Honorary Consultant Paediatric Immunologist at the Great North Children's Hospital. Prof. Gennery's research focuses on polysaccharide antibody responses, VDJ recombination in primary immunodeficiency, immune reconstitution post bone marrow transplantation, and immunodeficiency in DiGeorge syndrome. His work has greatly contributed to the treatment of primary immunodeficiency disorders.

## Antonio Condino-Neto

University of Sao Paolo, Brazil

Professor Antonio Condino-Neto, a renowned immunologist, recently retired from his position as Professor of Immunology and Experimental Medicine at the Institute of Biomedical Sciences, University of Sao Paulo. He now serves as Chief Medical Officer at Immunogenic Laboratories, São Paulo, and continues to direct the Jeffrey Modell Center of Primary Immunodeficiencies. Additionally, Prof. Condino-Neto acts as a Senior Scientific Consultant at Instituto Jô Clemente and Instituto Pensi / Hospital Sabará / Pediatric Allergy-Immunology. His expertise spans translational research, clinical trials, and medical practice in immunology, allergy, and primary immunodeficiencies. He will be delivering the third Professor Yu Lung Lau Oration.

## Brahim Belaid

Beni Messous Hospital Center, Algeria

Assistant Professor Brahim Belaid is a respected immunologist at the Department of Medical Immunology, Beni Messous Hospital Center, University of Algiers 1, Algeria. He also heads the Cellular Immunology and Flow Cytometry Unit within the department. Dr. Belaid's research interests include immunology, allergology, autoimmunity, immunodeficiencies, and immunogenetics. His work has made a significant impact on the understanding and treatment of various immunological disorders, contributing to the advancement of diagnostic immunology in the region.

## Daniel Leung

Organizing and Scientific Secretary
The University of Hong Kong, Hong Kong

Daniel Leung is an MBBS PhD student at the Department of Paediatrics and Adolescent Medicine at The University of Hong Kong. His research interests lie in understanding how genetic variations influence immunity and immune responses to vaccines. Utilizing advanced omics technologies, such as genome sequencing and transcriptomics, Daniel delves into the intricate relationships between the immune system and DNA. He was part of an international team that identified a novel inborn error, STAT6 gain-of-function defect, which underlies severe allergic diseases. As Organizing and Scientific Secretary, Daniel plays a key role in shaping the conference's scientific discourse.

## Fatima Jonie Santos Ocampo

Makati Medical Centre, the Philippines

Dr. Fatima J Santos Ocampo is a renowned Consultant in the Section of Allergy/Immunology at the Department of Pediatrics at the Makati Medical Center in Makati City, The Philippines. As the Representative of the Philippine Society of Allergy, Asthma, and Immunology, she plays a significant role in advancing the Asia Pacific Society for Immunodeficiencies and the field of IEI in the Philippines. Dr. Santos-Ocampo's expertise lies in the diagnosis and treatment of allergic and immunological disorders, making her a highly respected clinician in her field.

# Faculty

## Godfrey Chan

The University of Hong Kong, Hong Kong

Godfrey Chan is a highly respected Clinical Professor at the School of Clinical Medicine, The University of Hong Kong. He holds the prestigious Tsao Yen-Chow Endowed Professorship in Paediatrics and Adolescent Medicine. Additionally, he is the Director of the Molecular Laboratory for Traditional Chinese Medicine and the Service Head of Paediatric Oncology at the Hong Kong Children's Hospital. Prof. Chan's research focuses on the interactions between human mesenchymal stem cells, dendritic cells, and neuroblastoma cells, as well as the development of new treatment modalities for neurogenic tumors such as neuroblastoma and brain tumors. His work has significantly advanced the understanding and treatment of pediatric cancers, improving outcomes for young patients.

## Hans Ochs

Seattle Children's Hospital, USA

Hans Ochs is a highly distinguished Professor of Pediatrics at the Seattle Children's Hospital in the United States. He holds the prestigious Jeffrey Modell Endowed Chair in Pediatric Immunology Research and serves as the Principal Investigator for the Center for Immunity and Immunotherapies. Prof. Ochs' research interests encompass the molecular basis of primary immunodeficiency disorders, autoimmunity and immune dysregulation, regulatory T cells and mutations of FOXP3, and the eventual consequences of heterozygous hypermorphic STAT3 mutations and their relationship to autosomal dominant Hyper IgE syndrome.

He has made significant contributions to the field of pediatric immunology, including identifying the genes causative of Wiskott-Aldrich syndrome (WAS) and immune dysregulation, polyendocrinopathy, enteropathy, X-linked (IPEX) syndrome. Prof. Ochs' work has contributed significantly to the understanding and treatment of primary immunodeficiency disorders, improving patient outcomes and quality of life.

## Hirokazu Kanegane

Tokyo Medical and Dental University Hospital, Japan

Hirokazu Kanegane is a highly respected Professor of Immunology, Hematology, and Oncology at Tokyo Medical and Dental University in Japan. His research interests include primary immunodeficiency diseases, pediatrics, and fetal medicine. Prof. Kanegane is known for his innovative treatment approaches, which have improved patient outcomes. He is the President-elect of the Asia Pacific Society for Immunodeficiencies, a testament to his leadership and contributions to the field. His work has advanced the understanding of immunology and led to the development of innovative treatments for patients with immunodeficiency diseases.

## Huawei Mao

Beijing Children's Hospital, China

Huawei Mao is a Professor at Beijing Children's Hospital, Capital Medical University in China, and an expert in immunology, primary immunodeficiencies, and target therapy for autoinflammatory diseases. Dr. Mao's research interests also include the development of new therapeutic strategies for primary immunodeficiencies and hematopoietic stem cell transplant. He has published numerous research papers in high-impact journals, and is actively involved in teaching and training the next generation of immunologists in China. Dr. Mao is a member of the Chinese Society of Immunology and serves on the editorial board of several international immunology journals.

## Jaime Rosa Duque

Organizing and Scientific Chair
The University of Hong Kong, Hong Kong

Jaime Rosa Duque is a Clinical Assistant Professor at the University of Hong Kong and Queen Mary Hospital in Hong Kong. Dr. Duque's research focuses on vaccinology, allergy and IEI. He has published numerous research papers in high-impact journals, and is involved in teaching and training the next generation of immunologists. He is the Organizing and Scientific Chair for the Inaugural Advanced APSID IEI School.

## Kai N Cheong

Hong Kong Children's Hospital, Hong Kong

Dr. Kai N Cheong is an Associate Consultant in Paediatric Rheumatology & Immunology at the Hong Kong Children's Hospital. With a strong background in both paediatric immunology and rheumatology, he is dedicated to providing comprehensive care to children with complex immune and rheumatic disorders.

# Faculty

## Klaus Warnatz

Medical Center – University of Freiburg, Germany

Klaus Warnatz is a Senior Consultant at the Center for Chronic Immunodeficiency at the Medical Center of the University of Freiburg in Germany, specializing in primary and secondary immunodeficiency disorders of adults. His research interests include classification, diagnostics, and pathogenesis of disorders such as Common Variable Immunodeficiency (CVID), Idiopathic CD4 Lymphocytopenia (ICL), and Secondary Immunodeficiency due to Immunosuppressive Therapy. Prof. Warnatz has published extensively in high-impact journals and is involved in training the next generation of physicians and researchers in immunology and immunodeficiency disorders. Prof Warnatz will be joining virtually.

## Kohsuke Imai

National Defense Medical College Hospital, Japan

Kohsuke Imai is Professor and Department Head at National Defense Medical College Hospital in Japan, specializing in primary immunodeficiencies (PIDs). He is interested in genetic diagnosis, clinical database construction, and understanding the molecular mechanisms of PIDs, including hyper-IgM syndrome, combined immunodeficiency, common variable immunodeficiency, and B cell deficiency. He was the first to show human UNG deficiency caused hyper-IgM syndrome. Dr. Imai's research also focuses on hematopoietic stem cell transplantation and gene therapy for PIDs.

## Melanie Wong

Children's Hospital at Westmead, Australia

Melanie Wong is a clinical immunologist and co-head of the Immunology and Allergy Department at the Children's Hospital at Westmead in Australia. She is a Past President of the Australasian Society of Clinical Immunology and Allergy and is actively involved in medical education and training. Dr. Wong's clinical and research interests include primary immunodeficiencies, such as newborn screening, genetic testing, and transplantation.

## Mingsheng Ma

Peking Union Medical College Hospital

Mingsheng Ma is an Associate Professor in the Department of Pediatrics at Peking Union Medical College Hospital, Chinese Academy of Medical Sciences. He specializes in the diagnosis and treatment of pediatric immune diseases such as auto-inflammatory diseases, inborn errors of immunity, juvenile idiopathic arthritis, systemic sclerosis, as well as other rare genetic conditions in children like Prader-Willi syndrome and glycogen storage diseases. He has contributed to several national research projects, including the National Key Research & Development Program on Precision Diagnosis and Treatment for Pediatric Immune Diseases. Professor Ma has been recognized for his work with the Young Researcher Award from the Asian Society for Pediatric Research. He is a prolific author with publications in well-known scientific journals and is renowned for his commitment to improving the lives of children with complex and rare medical conditions.

## Narissara Suratannon

King Chulalongkorn Memorial Hospital, Thailand

Narissara Suratannon is an Assistant Professor at Chulalongkorn University in Bangkok, Thailand. She is a member of the Pediatric Allergy and Clinical Immunology Research Unit and is actively involved in research on allergy and immunology. Her research interests include immunotherapy, gut microbiome, allergic diseases, and prebiotics. She recently defined a novel IEI underlying severe allergic disease, STAT6 gain-of-function disease.

## Pamela P Lee

The University of Hong Kong, Hong Kong

Dr. Pamela P Lee is an Associate Professor in the Department of Paediatrics and Adolescent Medicine at the University of Hong Kong, as well as Assistant Dean (Clinical Curriculum) and Programme Director (Pedagogy and Training) at the Bau Institute of Medical and Health Sciences Education. Dr. Lee's research interests focus on inflammasome biology and the immunoregulatory mechanisms of type I interferon signaling, primary immunodeficiencies, and immunodysregulatory disorders. Her dedication to advancing knowledge in these areas has made her a respected expert in the field.

# Faculty

## Pandiarajan Vignesh

PGIMER Chandigarh, India

Pandiarajan Vignesh is an Associate Professor in the Department of Pediatrics at the Post Graduate Institute of Medical Education and Research (PGIMER) in Chandigarh, India. He specializes in pediatric immunology and pediatric rheumatology and has a strong research interest in these areas.

## Qing Zhou

Zhejiang University

Prof. Qing Zhou is an accomplished investigator at the Life Sciences Institute of Zhejiang University, China. She is known for her groundbreaking discoveries in novel inborn errors of immunity underlying autoinflammatory diseases, such as early-onset stroke and vasculopathy associated with ADA2 mutations, A20 haploinsufficiency due to TNFAIP3 loss-of-function mutations, and a dominantly inherited autoinflammatory disease with immunodeficiency caused by a hypermorphic missense mutation in PLCG2. Her most recent work revealed a low-ratio somatic NLRC4 mutation causing late-onset autoinflammatory disease. Dr. Zhou's research significantly advances the understanding of genetic influences on diseases and contributes to innovative therapeutic approaches.

## Satoshi Okada

Hiroshima University Hospital, Japan

Satoshi Okada is a Professor at the Graduate School of Biomedical and Health Sciences at Hiroshima University in Japan. He is a recognized expert in the field of inborn errors of immunity (IEI) and immunodeficiency and has made significant contributions to the understanding of these disorders. Dr. Okada's research interests include pediatrics and he has published research papers in many high-impact journals, including The Journal of Allergy and Clinical Immunology. His most notable contributions to the field of IEI include the discovery of human STAT1 gain-of-function disease and biallelic RORC deficiency.

## Stuart Turvey

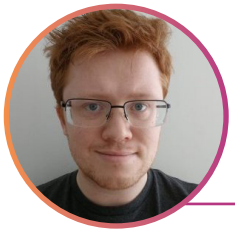
BC Children's Hospital, Canada

Stuart Turvey is a Professor in the Division of Allergy and Immunology at the University of British Columbia's Faculty of Medicine in Canada. He is an Investigator at BC Children's Hospital, Canada Research Chair in Pediatric Precision Health, and Aubrey J. Tingle Professor of Pediatric Immunology. His research focuses on the role of innate immunity in infectious and inflammatory diseases of childhood, using detailed immunological, genomic, and proteomic analyses. Dr. Turvey has published extensively in high-impact journals and has received numerous awards for his contributions to pediatric immunology research. In IEI, he most recently led the discovery of STAT6 gain-of-function disease, dominant IRF4 immunodeficiency, complete NFAT1 deficiency, and OSMR deficiency.

## Surjit Singh

PGIMER Chandigarh, India

Surjit Singh is a Professor at The Allergy Immunology Unit, Department of Pediatrics, Advanced Pediatrics Centre, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, India. He is the current President of the Asia Pacific Society for Immunodeficiencies. Dr. Singh's research interests include primary immunodeficiency, humoral immunodeficiency, combined immunodeficiency, and other aspects of pediatric immunology. He has published extensively in peer-reviewed journals and is highly regarded for his expertise in the field of primary immunodeficiencies.



## Thomas Whittaker

Great Ormond Street Hospital, UK

Tom Whittaker is a Postdoctoral Research Fellow at GOSH ICH. Tom received his undergraduate and Master's degrees in Biochemistry from the University of Cambridge, and received his Ph.D in Regenerative Medicine from Imperial College London. His current research focuses on gene therapy approaches using Lentivirus, Adeno-Associated Virus and CRISPR to treat primary immunodeficiencies, with a focus on Chronic Granulomatous Disease. He also works on developing new virus-free technologies for gene therapy to minimise toxicity and off-target effects in order to improve safety and long-term engraftment.

# Faculty

## Tomohiro Morio

Tokyo Medical and Dental University Hospital, Japan

Tomohiro Morio is a Professor in Pediatrics and Developmental Biology at Tokyo Medical and Dental University Hospital, Japan, and Vice President of Information and International Exchange at the same university. His research interests include immunodeficiency, infection, class switching, DNA damage response, and regenerative medicine. Prof. Morio is a member of the IUIS Expert Committee on IEI, and is an international leader in the field of IEI.

## Wanling Yang

The University of Hong Kong, Hong Kong

Wanling Yang is a Professor in the Department of Paediatrics and Adolescent Medicine at the School of Clinical Medicine, The University of Hong Kong. His research interests focus on genetic studies related to systemic lupus erythematosus (SLE), molecular diagnosis for Mendelian diseases, bioinformatics, and genomics. He has contributed to the identification of novel genetic factors that predispose to SLE and developed genomics pipelines for identifying disease-causing variants in Mendelian disorders, including IEI, thalassemia, and neuromuscular disorders.

## Wenwei Tu

The University of Hong Kong, Hong Kong

Wenwei Tu is a Professor of Department of Paediatrics and Adolescent Medicine at the University of Hong Kong. His research focuses on translational immunology, including viral immunology, transplantation immunology, and the development of humanized mouse models for studying human immune systems. He has made significant contributions to the understanding of immune responses to viral infections, such as HIV and influenza, and to the development of novel therapeutic approaches for treating viral infections and cancer.

## Wing Leung

The University of Hong Kong, Hong Kong

Professor Wing Leung is the Head of Department and Clinical Professor in the Department of Paediatrics and Adolescent Medicine at the School of Clinical Medicine, University of Hong Kong. He has a keen research interest in cell therapy for cancer and infectious diseases, as well as the paediatric immunome. His work focuses on exploring new treatment options for cancer and infectious diseases using cutting-edge techniques, and understanding the complex immune system in children. With his expertise, he has made significant contributions to the field of paediatric immunology and continues to drive advancements in this field.

## Woei Kang Liew

KK Women's and Children's Hospital, Singapore

Dr. Woei Kang Liew is a distinguished paediatrician with a sub-specialization in Paediatric Allergy, Immunology, and Rheumatology. He serves as the Genetics and Genomics Working Party Chair for the Asia Pacific Society for Immunodeficiencies (APSID) and represents the Allergy and Clinical Immunology Society of Singapore on the APSID Executive Board. Dr. Liew brings his expertise to the Rheumatology and Immunology Service at the renowned KK Women's and Children's Hospital in Singapore as a Visiting Senior Consultant Paediatrician.

## Xiaodong Zhao

Second Affiliated Hospital of Chongqing Medical University, China

Prof. Xiaodong Zhao is a highly respected Professor and President at the Second Affiliated Hospital of Chongqing Medical University in China. His research interests encompass Clinical Immunology and the pathogenesis of primary immunodeficiency diseases. Prof. Zhao's work delves into immune cell differentiation and memory establishment in cytoskeleton-related diseases, such as Wiskott-Aldrich syndrome and DOCK8 deficiency. Additionally, he is dedicated to identifying novel genes in primary immunodeficiency diseases and developing innovative therapeutic strategies. With his expertise and dedication, Prof. Zhao contributes significantly to the understanding and treatment of these rare conditions.

# Faculty

## Yae Jean Kim

Samsung Medical Center, Korea

Prof. Yae Jean Kim is a renowned Professor of Pediatrics at the Samsung Medical Center and Sungkyunkwan University School of Medicine in Korea. As a world-leading expert in human coronaviruses, her research has significantly impacted our understanding of these viruses. Prof. Kim's additional interests include paediatric infectious diseases, primary immune deficiency, tuberculosis, fever of unknown origin, travel medicine, and tropical medicine. Her contributions to the field have made her a highly respected authority in infectious diseases and an esteemed speaker at the Asia Pacific Society for Immunodeficiencies conference. Prof. Kim will be joining virtually.

## Youjia Zhong

National University Health System, Singapore

Dr. Youjia Zhong is an emerging young talent in the field of primary immunodeficiency diseases (PID) in Asia. As a Consultant Paediatrician at the Department of Paediatrics in National University Hospital, Singapore, she is dedicated to advancing the understanding and treatment of paediatric immunological disorders. Her research interests span paediatrics, clinical immunology, asthma, and allergy.

## Yu Lung Lau

APSID Founding President and School Chair
The University of Hong Kong, Hong Kong

Prof. Yu Lung Lau is the Founding President of APSID and serves as the Chair Professor of Paediatrics and Doris Zimmern Professor in Community Child Health at the University of Hong Kong. He has made significant strides in the field of immunodeficiencies, establishing the Asian PID Network and providing free molecular diagnostics to thousands of patients across Asia and Africa. His research interests include primary immunodeficiencies, systemic lupus erythematosus, immune responses to pathogens, modulation of immune cells by apoptotic cells, infectious diseases, vaccine studies, thalassaemia, and hematopoietic stem cell transplants. Prof. Lau is the School Chair for the Inaugural Advanced APSID IEI School.

## Yunfei An

Children's Hospital of Chongqing Medical University

Dr. Yunfei An is an Associate Professor at the Children's Hospital of Chongqing Medical University in Chongqing, China. With a strong background in pediatrics and pediatric immunology, he has devoted his career to advancing the understanding and treatment of immunodeficiencies, with a particular focus on hyper-IgE syndrome. Dr. An's research contributions and dedication to the field make him a highly respected emerging expert in IEI in China.

## Yuxia Zhang

Guangzhou Children's and Women's Medical Center, China

Dr. Yuxia Zhang is a Principal Investigator at the Guangzhou Women and Children's Medical Center in China. With her research published in prestigious journals such as Cell, Nature Immunology, Science Immunology, Science Translational Medicine, Blood, and the Journal of Allergy and Clinical Immunology, she has made a significant impact in the field of immunology. Dr. Zhang's research interests include bridging mouse and human immunology studies using cutting-edge genetic, epigenetic, metabolomic, and cell signaling methodologies. She focuses on identifying novel pathogenic mechanisms and therapeutic agents in pediatric-onset inflammatory, autoimmune, and allergic diseases, as well as understanding the molecular mechanisms underlying childhood autoinflammatory diseases and immunodeficiencies.

## Zarina Thasneem Zainudeen

Advanced Medical and Dental Institute (AMDI), Universiti Sains Malaysia

Dr. Zarina Thasneem Zainudeen is a dedicated Lecturer in Immunology at the Advanced Medical and Dental Institute (AMDI) of Universiti Sains Malaysia. Her research interests are centered on primary immunodeficiency diseases, functional assays, and immunology. Dr. Zainudeen's commitment to furthering knowledge in these areas has made her a vital young contributor to the field of immunology in Malaysia.

# Abstracts

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the Abstracts

克爾來福® CoronaVac®
新型冠狀病毒滅活疫苗

# A glance at pediatric use of CoronaVac®

## Global approval for use/ registration * of CoronaVac®

As of January 2023, **CoronaVac® is the only inactivated COVID-19 vaccine approved to use as young as 6 months old**. Currently, **62** countries, regions, and international organizations (IO) granted EUL of CoronaVac®, and **16** of them approved or granted EUL in the pediatrics population listed below:

| Country/ Region/ IO | Approved Age | Country | Approved Age |
|---|---|---|---|
| China | 3-17 years | Turkey | 3-17 years |
| Hong Kong SAR†^ | 6 months – 17 years | Dominican Republic | 5-17 years |
| Chile | 6 months – 17 years | Malaysia | 5-17 years |
| Cambodia | 3-17 years | Indonesia | 6-17 years |
| Colombia | 3-17 years | Thailand | 6-17 years |
| Ecuador | 3-17 years | Philippines | 6-17 years |
| Brazil | 3-17 years | Myanmar | 12-17 years |
| World Health Organization | 3-17 years | Zimbabwe | 16-17 years |

EUL: Emergency Use Listing.
*: EUL or conditional approval.
†: Use of CoronaVac in 6 months to 3 years old is off-label.
^: CoronaVac® is officially registered in Hong Kong for people aged 3 years and above in accordance with Cap. 138A since 22th Dec 2022.

Declaration: This material is a news update on the latest global approval or EUL of CoronaVac in peadiatric only. Sinovac does not have any intention on promoting off-label use.

CoronaVac 2023 DA-05-EN

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Hizentra®
Immune Globulin Subcutaneous (Human) 20% Liquid

# INFUSING INNOVATION
into Ig Therapy

## Proven protection around the world.
## Personalised treatment around each PID patient.

- **#1 Ig** used worldwide for PID[1]
- **11.3 million+** exposures worldwide[1]
- Only SCIG with **12+ years** of proven efficacy and tolerability[1,2]
- Approved in **60+ countries**[1,2]
- **215,000+** patient-years of experience[1]
- **1st 20% SCIG** in the market[3]

## Established Efficacy

- Effective, consistent IgG levels delivered with Hizentra[4]
- None of the patients had a serious bacterial infection during the efficacy period of the study[4]
- Steady-state rapidly achieved and high IgG levels maintained with Hizentra[4]

## Tolerability and Safety

### Good tolerability[4]

- Patients' perceptions of local tolerability was good or very good in over 96% of infusions[4]
- There were no serious adverse events related to study medication[4]
- The most common adverse event was local reaction at infusion site[4]

**Before prescribing, please review the approved Hong Kong Package Insert.**

**HIZENTRA®.** Solution for subcutaneous injection. **Qualitative and quantitative composition:** Human normal IgG, 200mg/ml (purity ≥98% IgG). IgA≤50 µg/ml. Other ingredients: L-proline, Polysorbate 80. Hizentra is essentially sodium-free, contains no preservatives. **Therapeutic indications:** Replacement therapy in primary immunodeficiency syndromes with impaired antibody production; hypogammaglobulinaemia & recurrent bacterial infections in chronic lymphocytic leukaemia patients, in whom prophylactic antibiotics have failed or are contraindicated; hypogammaglobulinaemia & recurrent infections in multiple myeloma patients; hypogammaglobulinaemia in pre- & post-allogeneic haematopoietic stem cell transplantation patients. Immunomodulatory therapy in patients with chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance after stabilization with IVIg. **Contraindications:** Hypersensitivity to the active substance/excipients. Hyperprolinaemia I or II. **Undesirable effects:** Adverse reactions such as chills, headache, fever, vomiting, allergic reactions, nausea, arthralgia, low blood pressure and moderate low back pain may occur occasionally. Rarely human normal immunoglobulins may cause a sudden fall in blood pressure and in isolated cases, anaphylactic shock, even when the patient has shown no hypersensitivity to previous administration. Local reactions at infusion sites: swelling, soreness, redness, induration, local heat, itching, bruising and rash. **Manufacturer:** CSL Behring AG Bern. **Date of revision of the text:** July 2021.

Biotherapies for Life™ CSL Behring

**CSL Behring Asia Pacific Limited**
4205 - 4208, AIA Tower, 183 Electric Road,
North Point, Hong Kong
HKG-HIZ-07220001
Date of preparation: Jul 2022

**References:**
1. Data on File. Available from CSL Behring as DOF HIZ-005.
2. Data on File. Available from CSL Behring as DOF HIZ-004.
3. CSL Behring [press release]. CSL Behring receives FDA approval of Hizentra™, first 20 percent subcutaneous immunoglobulin therapy. CSL Behring website. https://www.cslbehring.com/newsroom/2010/20100304-hizentra-approval. Published Mar 4, 2010. Accessed January 24, 2022.
4. Jolles S, et al. Efficacy and safety of Hizentra® in patients with primary immunodeficiency after a dose-equivalent switch from intravenous or subcutaneous replacement therapy. Clin Immunol. 2011;141:90-102.

privigen™
Immune Globulin Intravenous (Human), 10% Liquid
IVIg therapy made simple

# Advancing Ig therapy. The first and only proline-stabilised 10% liquid human IVIg[1]

**85+ Countries[2] | 1,000,000+ Patient-years exposure[3]**

- Convenient, ready-to-use 10% liquid IgG[4]
- ≥98% Ig purity—only trace amounts of IgA (≤25 mcg/mL)[4]
- If well-tolerated, the rate of administration may gradually be increased to 4.8 mL/kg bw/hour[4]
- Multiple indications: PID, SID, CIDP, ITP, GBS, MMN, and Kawasaki disease[4]

***Before prescribing, please review the approved Hong Kong Package Insert, November 2021***

Privigen Human normal immunoglobulin solution for infusion (10%)

**Indication:** Replacement therapy in adults, and children and adolescents (0-18 years) in: • Primary immunodeficiency syndromes (PID) with impaired antibody production; • Secondary immunodeficiencies (SID) in patients who suffer from severe or recurrent infections, ineffective antimicrobial treatment and either proven specific antibody failure (PSAF)* or serum IgG level of <4 g/l. Immunomodulation in adults, and children and adolescents (0-18 years) in: • Primary immune thrombocytopenia (ITP), in patients at high risk of bleeding or prior to surgery to correct the platelet count; •Guillain-Barré syndrome; • Kawasaki disease(in conjunction with acetylsalicylic acid); • Chronic inflammatory demyelinating polyneuropathy (CIDP). Only limited experience is available of use of intravenous immunoglobulins in children with CIDP; • Multifocal motor neuropathy (MMN). ** PSAF = failure to mount at least a 2-fold rise in IgG antibody titre to pneumococcal polysaccharide and polypeptide antigen vaccines.* **Dosage:** In replacement therapy the dose may need to be individualised for each patient depending on the clinical response. *Replacement therapy in primary immunodeficiency (PID) syndromes* The recommended starting dose is 0.4 to 0.8 g/kg body weight (bw) given once, followed by at least 0.2 g/kg bw every 3 to 4 weeks. *Secondary immunodeficiencies* The recommended dose is 0.2 – 0.4g/kg bw every three to four weeks. *Primary immune thrombocytopenia (ITP)* • 0.8 to 1g/kg bw given on day 1; this dose may be repeated once within 3 days, OR •0.4 g/kg bw given daily for 2 to 5 days. *Guillain-Barré syndrome* 0.4 g/kg bw/day over 5 days. Kawasaki disease 2.0 g/kg bw should be administered as a single dose. Patients should receive concomitant treatment with acetylsalicylic acid. *Chronic inflammatory demyelinating polyneuropathy (CIDP)* The recommended starting dose is 2 g/kg bw divided over 2 to 5 consecutive days followed by maintenance doses of 1 g/kg bw over 1 to 2 consecutive days every 3 weeks. *Multifocal Motor Neuropathy (MMN)* Starting dose: 2 g/kg given over 2-5 consecutive days. Maintenance dose: 1 g/kg every 2 to 4 weeks or 2 g/kg every 4 to 8 weeks. **Method of administration:** For intravenous use. Privigen should be infused intravenously at an initial infusion rate of 0.3 ml/kg bw/hr for approximately 30 min. If well tolerated, the rate of administration may gradually be increased to 4.8 ml/kg bw/hr. In PID patients who have tolerated the infusion rate of 4.8 ml/kg bw/hr well, the rate may be further gradually increased to a maximum of 7.2 ml/kg bw/hr. **Contraindications:** Hypersensitivity. Patients with selective IgA deficiency who developed antibodies to IgA. Patients with hyperprolinaemia type I or II. **Precautions:** Not indicated in patients with selective IgA deficiency where the IgA deficiency is the only abnormality of concern. Caution for hypersensitivity, haemolytic anaemia, aseptic meningitis syndrome, thromboembolism, acute renal failure, pulmonary adverse reactions, interference with serological testing, possibility of transmissible agents. In case of adverse reaction, IVIg products should be administered at the minimum rate of infusion and dose practicable. Privigen does not contain sucrose, maltose or glucose. Privigen contains less than 2.3 mg sodium per 100 ml. **Undesirable effects:** Headache, pain, pyrexia, influenza like illness, anaemia, haemolysis β, leukopenia, hypersensitivity, dizziness, hypertension, flushing, hypotension, dyspnoea, nausea, vomiting, diarrhoea, abdominal pain, hyperbilirubinaemia, skin disorder, myalgia, fatigue, asthenia, decreased haemoglobin, Coombs`(direct) test positive, increased alanine aminotransferase, increased aspartate aminotransferase, increased blood lactate dehydrogenase. **Date of last revision of PI:** Nov 2021



***References***

***1.*** *Morio T, et al. Immunological Medicine 2019; 42:4, 162-168* ***2.*** *Data on file. Available from CSL Behring as DOF-PRI-10019.* ***3.*** *Data on file. Available from CSL Behring as DOF-PRI-10020.* ***4.*** *Hong Kong Privigen Package Insert, Nov 2021*


*Ig: immunoglobulin; IVIg: intravenous immunoglobulin; bw: body weight; PID: Primary immunodeficiency syndromes; SID: Secondary immunodeficiencies; CIDP: Chronic inflammatory demyelinating polyneuropathy; ITP: Primary immune thrombocytopenia; GBS: Guillain-Barré syndrome; MMN: Multifocal Motor Neuropathy*

Biotherapies for Life™ **CSL Behring**


**CSL Behring Asia Pacific Limited**
4205 - 4208, AIA Tower, 183 Electric Road
North Point, Hong Kong


HKG-PVG-11220008
Date of preparation: Nov 2022


[a] 某些HPV相關癌症[1]
[b] HPV相關癌症的治療方法或有機會導致不育[2]

以上資料只供參考用途，詳情必須向醫生查詢

英國默沙東醫藥有限公司 | 香港銅鑼灣恩平道28號利園二期27樓 | 電話：(852) 3971 2800 | 傳真：(852) 2834 0756



資料來源: 1. American Cancer Society. Surgery for Anal Cancer. Available at: https://www.cancer.org/cancer/anal-cancer/treating/surgery.html. Accessed on 5 Sep 2022.
2. American Cancer Society. Radiation Therapy for Anal Cancer. Available at: https://www.cancer.org/cancer/anal-cancer/treating/radiation-therapy.html. Accessed on: 19 Sep 2022.

www.hpv.com.hk
fight hpv
fight.hpv

MSD


*適齡時

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資料來源：1. NCIRS. Human papillomavirus (HPV). Available at: https://ncirs.org.au/sites/default/files/2018-12/HPV%20Factsheet_2018%20Aug%20Update_final%20for%20web.pdf. Accessed on 5 Sep 2022.

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# Paxlovid™

(nirmatrelvir 150 mg tablets | ritonavir 100 mg tablets)

# The first oral protease inhibitor designed to treat COVID-19[1,2]

## PAXLOVID™ can reduce the risk of COVID-19 related hospitalisation or death by[2,3]*:

**88%**

* Reduced risk of COVID-19 related hospitalisation or death from any cause vs. placebo through day 28 in symptomatic adult patients - at high risk for progression to severe COVID-19 - treated within 5 days of symptom onset in a phase 2/3 clinical trial.

**References:** 1. Lamb YN. Nirmatrelvir plus Ritonavir: first approval. *Drugs*. 2022;19:1-7. 2. Owen DR, Allerton CMN, Anderson AS, *et al*. An oral SARS-CoV-2 Mpro inhibitor clinical candidate for the treatment of COVID-19. *Science*. 2021;374(6575): 1586-1593. 3. Hammond J, Leister-Tebbe H, Gardner A, *et al*. Oral nirmatrelvir for high-risk, nonhospitalized adults with Covid-19. *N Engl J Med*. Published online February 16, 2022. doi:10.1056/NEJMoa2118542.

**Find Additional Information**
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Pfizer

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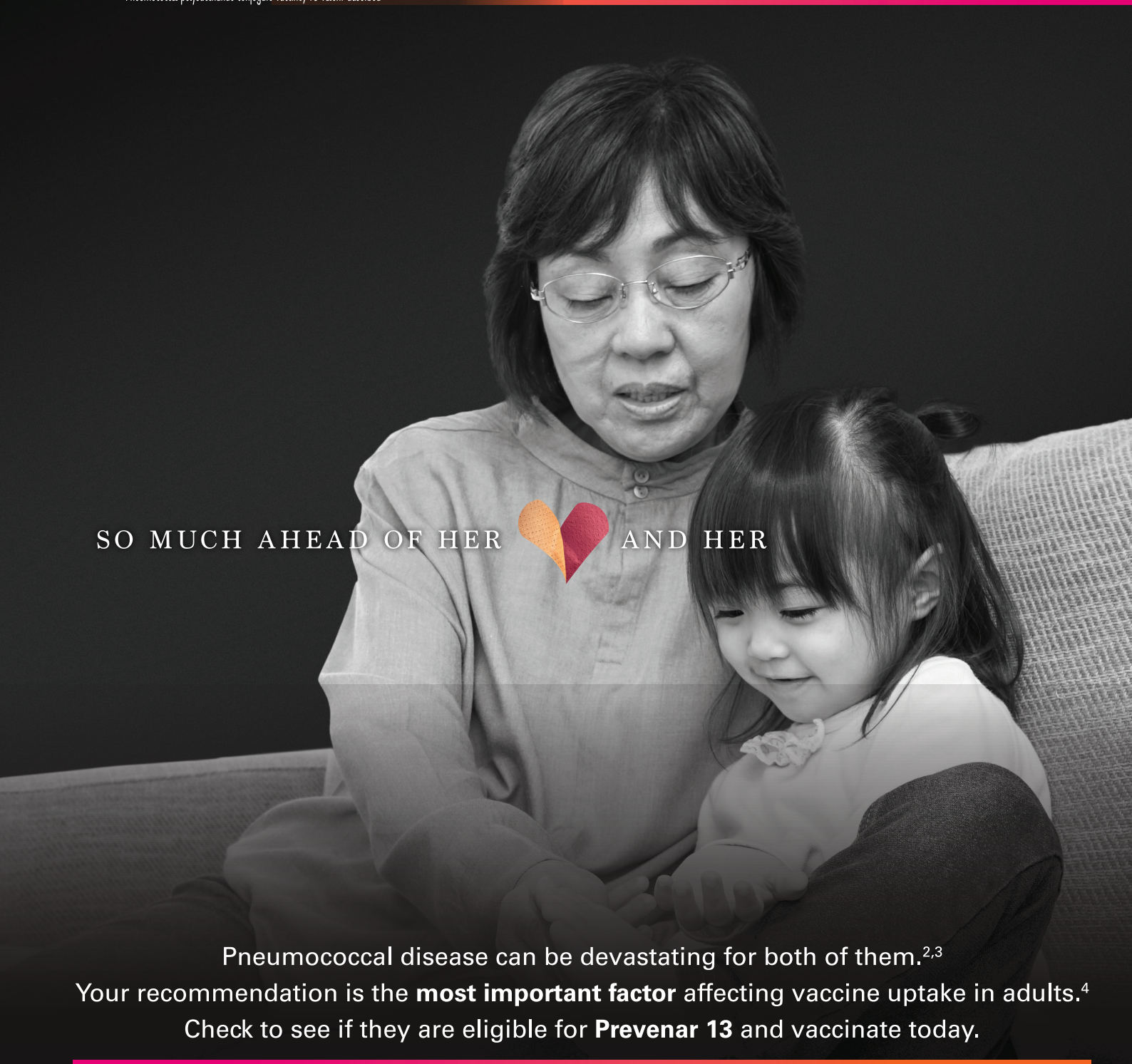
Website: www.pfizer.com.hk PP-PAX-HKG-0013 Aug 2022

# Prevenar 13®

Pneumococcal polysaccharide conjugate vaccine, 13-valent adsorbed

## FUNDED FOR ADULTS TOO[1,5*]




Pneumococcal disease can be devastating for both of them.[2,3]
Your recommendation is the **most important factor** affecting vaccine uptake in adults.[4]
Check to see if they are eligible for **Prevenar 13** and vaccinate today.

Scan the QR code or type the URL in your browser to find the full prescribing information of Prevenar 13

https://pfi.sr/JzA

The QR code/URL links to the latest Prescribing Information approved by the Department of Health in Hong Kong and may not be effective and the same as presented in the actual product package.

* Aged 65 years or above with high-risk conditions.

High risk conditions include the following:

(a) History of invasive pneumococcal disease
(b) Immunocompromised states:
- Asplenia, HIV/AIDS, primary immunodeficiency
- Immunodeficiencies related to malignancy and transplantation
- Immunodeficiencies related to use of immunosuppressive drugs / systemic steroid

(c) Chronic disease:
- Chronic cardiac, pulmonary, liver or renal disease
- Diabetes mellitus or CSF leakage

(d) With cochlear implants

**For Healthcare Professionals only**

**References: 1.** Centre for Health Protection. The Government of the HKSAR. Statistics on Antimicrobial Resistance Control. Pneumococcal vaccination. Available at: https://www.chp.gov.hk/en/statistics/data/10/100044/6870.html. Accessed 14 Mar 2023. **2.** Pelton SI *et al. Clin Infect Dis* 2014;59:615–23. **3.** Patel C *et al. Commun Dis Intell* (2018) 2022;46. doi: https://doi.org/10.33321/cdi.2022.46.28. **4.** Briggs L *et al. Vaccine* 2019;37:4454–59. **5.** Centre for Health Protection. The Government of the HKSAR. Scientific Committee on Vaccine Preventable Diseases. Updated Recommendations on the Use of Pneumococcal Vaccines for High-risk Individuals. Available at: https://www.chp.gov.hk/files/pdf/updated_recommendations_on_the_use_of_pneumococcal_vaccines_amended_120116_clean_2.pdf. Accessed 14 Mar 2023

Pfizer

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BEXSERO

Meningococcal Group B Vaccine
(rDNA, component, adsorbed)

# THE **ONLY** MENINGOCOCCAL B VACCINE INDICATED FOR PAEDIATRIC* PATIENTS[1,2].

**16 YEARS OLD** —
Study abroad

**3 YEARS OLD** —
Toilet trained

**1 YEAR OLD** —
First tooth
(and BEXSERO booster)

**2 MONTHS AFTER 1ST DOSE** —
2nd BEXSERO dose

**2 MONTHS ONWARDS** —
1st BEXSERO dose

* Below 10 years old


**References**
1. BEXSERO Hong Kong Prescribing Information GDS11.
2. Pfizer Ltd. Trumenba. Annex I: Summary of product characteristics. EMA; May 2018.


**Safety Information**
Hypersensitivity to any components of BEXSERO is a contraindication to administration. Administration of BEXSERO should be postponed in subjects suffering from an acute severe febrile illness. Minor infection, such as cold, should not result in the deferral of vaccination. BEXSERO should not be given to individuals with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection, unless the potential benefit clearly outweighs the risk of administration. Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following administration of BEXSERO.
Anxiety-related reactions, including vasovagal reactions (syncope), hyper-ventilation or stress-related reactions may occur in association with vaccination as a psychogenic response to the needle injection. It is important that procedures are in place to avoid injury from fainting.
The safety and efficacy of BEXSERO in individuals above 50 years of age have not been established. There are limited data in patients with chronic medical conditions and with impaired immune responsiveness (complement deficiency, asplenia or splenic dysfunction). In immunocompromised individuals, vaccination may not result in a protective antibody response. Insufficient clinical data on exposed pregnancies are available and there are no data on fertility in humans.
BEXSERO is not expected to provide protection against all circulating meningococcal group B strains.
The most common adverse reactions observed in clinical trials of infants and children were tenderness and erythema at the injection site, fever, and irritability. Fever occurred more frequently when BEXSERO was co-administered with other routine infant vaccines than when it was given alone.
Higher rates of antipyretic use were also reported for infants vaccinated with BEXSERO and routine vaccines. When BEXSERO was given alone, the frequency of fever was similar to that associated with routine infant vaccines administered during clinical trials. When fever occurred, it generally followed a predictable pattern, with the majority resolving by the day after vaccination.
Prophylactic use of paracetamol reduces the incidence and severity of fever without affecting the immunogenicity of either BEXSERO or routine vaccines. Antipyretic medication should be initiated according to local guidelines in infants and children (less than 2 years of age).
Due to an increased risk of fever, tenderness at the injection site, change in eating habits and irritability when BEXSERO was co-administered with routine vaccines, separate vaccinations can be considered when possible.
In adolescents and adults, the most common local and systemic adverse reactions observed were pain at the injection site, malaise and headache.
Less commonly, some serious events can occur after BEXSERO: seizures (including febrile seizures) and allergic reactions.

**Abbreviated Prescribing information**
**Product Name:** *Bexsero*. **Active Ingredient:** 1 dose (0.5ml) contains 50 µg recombinant *Neisseria meningitidis* group B NHBA fusion protein; 50 µg recombinant *Neisseria meningitidis* group B NadA protein; 50 µg recombinant Neisseria meningitidis group B fHbp fusion protein; 25 µg outer membrane vesicles (OMV) from Neisseria meningitidis group B strain NZ98/254 measured as amount of total protein containing the PorA P1.4. Indication: active immunisation of individuals from 2 months of age and older against invasive meningococcal disease caused by *Neisseria meningitidis* group B. **Posology and method of administration:** Please refer to the posology in the full prescribing information of Bexsero for details. The vaccine is given by deep intramuscular injection, preferably in the anterolateral aspect of the thigh in infants or in the deltoid muscle region of the upper arm in older subjects. Separate injection sites must be used if more than one vaccine is administered at the same time. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Special warnings and precautions for use:** As with other vaccines, administration of Bexsero should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as cold, should not result in the deferral of vaccination. Do not inject intravascularly. As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following the administration of the vaccine. Anxiety-related reactions, including vasovagal reactions (syncope), hyperventilation or stress-related reactions may occur in association with vaccination as a psychogenic response to the needle injection (see section 4.8). It is important that procedures are in place to avoid injury from fainting. This vaccine should not be given to individuals with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection, unless the potential benefit clearly outweighs the risk of administration. As with any vaccine, vaccination with Bexsero may not protect all vaccine recipients. Bexsero is not expected to provide protection against all circulating meningococcal group B strains. (see section 5.1). As with many vaccines, healthcare professionals should be aware that a temperature elevation may occur following vaccination of infants and children (less than 2 years of age). Prophylactic administration of antipyretics at the time and closely after vaccination can reduce the incidence and intensity of post-vaccination febrile reactions. Antipyretic medication should be initiated according to local guidelines in infants and children (less than 2 years of age). Individuals with impaired immune responsiveness, whether due to the use of immune-suppressive therapy, a genetic disorder, or other causes, may have reduced antibody response to active immunisation. Immunogenicity data are available in individuals with complement deficiencies, asplenia, or splenic dysfunctions (see section 5.1). There are no data on the use of Bexsero in subjects above 50 years of age and limited data in patients with chronic medical conditions. The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation series to very premature infants (born ≤ 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in this group of infants, vaccination should not be withheld or delayed. Kanamycin is used in early manufacturing process and is removed during the later stages of manufacture. If present, kanamycin levels in the final vaccine are less than 0.01 micrograms per dose. The safe use of Bexsero in kanamycin-sensitive individuals has not been established. **Interaction with other medicinal products and other forms of interaction:** Clinical studies demonstrated that the immune responses of the co-administered routine vaccines were unaffected by concomitant administration of Bexsero, based on non-inferior antibody response rates to the routine vaccines given alone. Due to an increased risk of fever, tenderness at the injection site, change in eating habits and irritability when Bexsero was co administered with the above vaccines, separate vaccinations can be considered when possible. When given concomitantly with other vaccines Bexsero must be administered at separate injection sites. **Pregnancy and lactation: Pregnancy:** Insufficient clinical data on exposed pregnancies are available. The potential risk for pregnant women is unknown. Nevertheless, vaccination should not be withheld when there is a clear risk of exposure to meningococcal infection. **Lactation:** Information on the safety of the vaccine to women and their children during breast-feeding is not available. The benefit-risk ratio must be examined before making the decision to immunise during breast-feeding. **Fertility:** There are no data on fertility in humans. **Undesirable effects:** Infants and children (up to 10 years of age): eating disorders; sleepiness; unusual crying; headache; seizures (including febrile seizures); pallor; Kawasaki syndrome; diarrhoea; vomiting; rash; eczema; urticaria; arthralgia; fever ≥38°C, fever ≥40°C), injection site tenderness (including severe injection site tenderness defined as crying when injected limb is moved), injection site erythema, injection site swelling, injection site induration, irritability. Adolescents (from 11 years of age) and adults: headache; nausea; myalgia; arthralgia; injection site pain (including severe injection site pain defined as unable to perform normal daily activity), injection site swelling, injection site induration, injection site erythema, malaise. **Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong.** Abbreviated Prescribing Information prepared in Jul 2019 based on version K052020(GDS11/EMA20200505).For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong) or (853) 2871 5569 (Macau), or send an email to us at HKAdverseEvent@gsk.com.

**Please read the full prescribing information prior to administration. Full prescribing information is available on request from GlaxoSmithKline Ltd, 23/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong.**

**For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8989 (Hong Kong) or (853) 2871 5569 (Macau), or send an email to us at HKAdverseEvent@gsk.com.**

**The material is for the reference and use by healthcare professionals.**




PM-HK-BEX-PSTR-210002 (07/2023)
Date of preparation: 25/08/2021

# WE ARE INCREDIBLY GRATEFUL FOR YOUR INCREDIBLE SUPPORT THROUGHOUT THE COVID-19 PANDEMIC

## LET'S CREATE A BRIGHTER FUTURE TOGETHER

FOSUN PHARMA
复星医药

## COMIRNATY® BIVALENT VACCINE: FOR ADDED PROTECTION AGAINST COVID-19 ILLNESS

- Matches with the currently circulating strain, keeping your protection against COVID-19 up to date[1]
- Reduces your risk of getting severe and life-threatening COVID-19 illness[2]
- Shows a similar safety profile to that of the monovalent booster vaccine[3]

**Abbreviation:** COVID-19, coronavirus disease 2019

**References: 1.** Link-Gelles R, et al. *MMWR Morb Mortal Wkly Rep.* 2023;72(5):119-24. **2.** Lin DY, et al. *N Engl J Med.* 2023. doi:10.1056/NEJMc2215471. **3.** Hause AM, et al. *MMWR Morb Mortal Wkly Rep.* 2022;71(44):1401-6.

**Abbreviated Product Information**

**PRODUCT NAME:** Comirnaty® Original/Omicron BA.4-5 (15/15 micrograms)/dose dispersion for injection **COMPOSITION:** One vial (2.25 mL) contains 6 doses of 0.3 mL, see sections 4.2 and 6.6. One dose (0.3 mL) contains 15 micrograms of tozinameran and 15 micrograms of famtozinameran, a COVID-19 mRNA Vaccine (embedded in lipid nanoparticles). **INDICATION:** Active immunisation to prevent COVID-19 caused by SARS-CoV-2, in individuals 12 years of age and older who have previously received at least a primary vaccination course against COVID-19 **POSOLOGY AND METHOD OF ADMINISTRATION:** Comirnaty® Original/Omicron BA.4-5 (15/15 micrograms)/dose dispersion for injection should be administered intramuscularly. Do not dilute prior to use. **INSTRUCTION:** Comirnaty® is supplied as a ready for injection intramuscularly. Vials contain 6 doses of 0.3 mL of vaccine. In order to extract 6 doses from a single vial, low dead-volume syringes and/or needles should be used. The low dead-volume syringe and needle combination should have a dead volume of no more than 35 microlitres. If standard syringes and needles are used, there may not be sufficient volume to extract a sixth dose from a single vial. Irrespective of the type of syringe and needle: • Each dose must contain 0,3 mL of vaccine, • If the amount of vaccine remaining in the vial cannot provide a full dose of 0,3 mL, discard the vial and any excess volume, • Do not pool excess vaccine from multiple vials, The preferred site is the deltoid muscle of the upper arm. Do not inject the vaccine intravascularly, subcutaneously or intradermally. The vaccine should not be mixed in the same syringe with any other vaccines or medicinal products. **CONTRAINDICATION:** Patients known to have hypersensitivity to the drug or any of its components. **PRECAUTIONS AND WARNINGS:** Hypersensitivity and anaphylaxis Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic reaction following the administration of the vaccine. Close observation for at least 15 minutes is recommended following vaccination. No further dose of the vaccine should be given to those who have experienced anaphylaxis after a prior dose of Comirnaty®. Myocarditis and pericarditis There is an increased risk of myocarditis and pericarditis following vaccination with Comirnaty®. These conditions can develop within just a few days after vaccination and have primarily occurred within 14 days. They have been observed more often after the second vaccination, and more often in younger males. Available data suggest that the course of myocarditis and pericarditis following vaccination is not different from myocarditis or pericarditis in general. Anxiety-related reactions Anxiety-related reactions, including vasovagal reactions (syncope), hyperventilation or stress-related reactions (e.g., dizziness, palpitations, increases in heart rate, alterations in blood pressure, paraesthesia, hypoaesthesia and sweating) may occur in association with the vaccination process itself. Stress-related reactions are temporary and resolve on their own. Individuals should be advised to bring symptoms to the attention of the vaccination provider for evaluation. It is important that precautions are in place to avoid injury from fainting. Concurrent illness Vaccination should be postponed in individuals suffering from acute severe febrile illness or acute infection. Thrombocytopenia and coagulation disorders As with other intramuscular injections, the vaccine should be given with caution in individuals receiving anticoagulant therapy or those with thrombocytopenia or any coagulation disorder (such as haemophilia) because bleeding or bruising may occur following an intramuscular administration in these individuals. No data are available yet regarding the use of Comirnaty® Original/Omicron BA.4-5 during pregnancy. No data are available yet regarding the use of Comirnaty® Original/Omicron BA.4-5 during breast-feeding. **ADVERSE REACTIONS:** Participants 18 to ≤ 55 years of age – after a booster dose of monovalent Omicron BA.1 (fourth dose) injection site pain, fatigue, headache, myalgia, chills and arthralgia. **INTERACTION:** No interaction studies have been performed. Concomitant administration of Comirnaty® Original/Omicron BA.4-5 with other vaccines has not been studied. **PRESENTATION:** Packs of 1 vial containing 2.25 ml of solution Comirnaty® is a Registered marketed by Fosun Pharma under license by BioNTech
For detailed Information, please refer to the Full Prescribing Information of Comirnaty® Original/Omicron BA.4-5 (15/15 micrograms)/dose dispersion for injection

This material is strictly meant for Healthcare Professionals (HCPs) only.

VAC-Feb23-014

FOSUN PHARMA
复星医药

**Fosun Industrial Co., Limited**
A106-A108, 16/F, Tower 5, The Gateway, Harbour City, Kowloon, Hong Kong
Tel: +852 800938618
Email: infohk@fosunpharma.com

COMIRNATY®
Original/Omicron BA.4-5

克爾來福® CoronaVac®
新型冠狀病毒滅活疫苗

# A glance at pediatric use of CoronaVac®

## Global approval for use/ registration * of CoronaVac®

As of January 2023, **CoronaVac® is the only inactivated COVID-19 vaccine approved to use as young as 6 months old**. Currently, **62** countries, regions, and international organizations (IO) granted EUL of CoronaVac®, and **16** of them approved or granted EUL in the pediatrics population listed below:

| Country/ Region/ IO | Approved Age | Country | Approved Age |
|---|---|---|---|
| China | 3-17 years | Turkey | 3-17 years |
| Hong Kong SAR†^ | 6 months – 17 years | Dominican Republic | 5-17 years |
| Chile | 6 months – 17 years | Malaysia | 5-17 years |
| Cambodia | 3-17 years | Indonesia | 6-17 years |
| Colombia | 3-17 years | Thailand | 6-17 years |
| Ecuador | 3-17 years | Philippines | 6-17 years |
| Brazil | 3-17 years | Myanmar | 12-17 years |
| World Health Organization | 3-17 years | Zimbabwe | 16-17 years |

EUL: Emergency Use Listing.
*: EUL or conditional approval.
†: Use of CoronaVac in 6 months to 3 years old is off-label.
^: CoronaVac® is officially registered in Hong Kong for people aged 3 years and above in accordance with Cap. 138A since 22th Dec 2022.

Declaration: This material is a news update on the latest global approval or EUL of CoronaVac in peadiatric only. Sinovac does not have any intention on promoting off-label use.

CoronaVac 2023 DA-05-EN

SINOVAC科兴

Sinovac Biotech (Hong Kong) Limited
Room 1906, 19/F,Lucky Commercial Building
103 Des Voeux Road West, Hong Kong, P.R.C.

Tel: +852 5548 0884
Email: info@sinovac.com
Website: www.sinovac.com

# ACHIEVE LASTING CHANGE

DUPIXENT® (dupilumab)
CONTINUOUS CONTROL

## ~340,000 AD PATIENTS TREATED WITH DUPIXENT WORLDWIDE[19]

*DUPIXENT is indicated to treat adults and adolescents ≥12 years with moderate-to-severe atopic dermatitis, and children aged 6 to 11 years with severe atopic dermatitis who are candidates for systemic therapy[1]

DUPIXENT is the first-line systemic choice for achieving lasting change in patients as young as 6 years old with atopic dermatitis (AD)*

### RAPID AND SUSTAINED CONTROL – CONSISTENT ACROSS ALL AGES

- Sustained improvement of itch, skin clearance, and QoL up to 52 weeks, with rapid control after first dose[1–16]

### UNIQUE LONG-TERM SAFETY PROFILE

Only AD therapy:

- With 4-years long-term safety data in adults[17]
- Approved in patients as young as 6 years old[1]

### START WITH EASE, STAY WITH CONFIDENCE

- DUPIXENT is not an immunosuppressant[1]
- 85% patient satisfaction with DUPIXENT treatment at 1 year[18**]

AD, atopic dermatitis; QoL, quality of life.
**adult population only

**References:** 1. DUPIXENT Summary of Product Characteristics. 2022. 2. Blauvelt A et al. Lancet 2017; 389:2287–2303. 3. Data on file (AD-1224 CSR). Sanofi and Regeneron Pharmaceuticals, Inc. 2016. 4. Blauvelt A et al. Lancet 2017; 389:2287–2303. [suppl.]. 5. Data on file (AD-1224 CSR DLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2021. 6. Data on file (AD-1652 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 7. Data on file (AD-1652 CSR CDLQI rate). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 8. Paller AS et al. J Am Acad Dermatol 2020; 83(5):1282–1293. 9. Cork MJ et al. Poster presented at the Revolutionizing Atopic Dermatitis Conference; 2021; June 13; Virtual Conference. Poster 468. 10. Data on file (AD-1652 CSR pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 11. Simpson EL et al. JAMA Dermatol 2020; 156(1):44–56. 12. Data on file (AD-1526 CSR EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2019. 13. Paller AS et al. Am J Clin Dermatol 2020; 21:119–131. 14. Data on file (AD-1539 EASI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 15. Data on file (AD-1539 pruritus NRS). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 16. Data on file (AD-1539 CDLQI). Sanofi and Regeneron Pharmaceuticals, Inc. 2022. 17. Beck L et al. Am J Clin Derm 2022; May;23(3):393-408. 18. Strober B et al. JAMA Dermatol 2022:158(2):142–150. 19. Data on file (Patient numbers, May 2022). Sanofi and Regeneron Pharmaceuticals, Inc. 2022.

**Presentation:** Dupilumab solution for injection in a pre-filled syringe with needle shield. **Indications:** *Atopic Dermatitis (AD):* Moderate-to-severe AD in adults and adolescents ≥12 years who are candidates for systemic therapy; severe atopic dermatitis in children 6 to 11 years old who are candidates for systemic therapy. *Asthma:* In adults and adolescents ≥12 years as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment. *Chronic rhinosinusitis with nasal polyposis (CRSwNP):* As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control(for 300 mg) **Dosage & Administration:** Subcutaneous injection. *AD adults:* Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. *ADadolescents(12-17y/o):* Body weight <60 kg - initial dose of 400 mg (two 200 mg injections), followed by 200 mg every other week. Body weight ≥60 kg - same dosage as adults. Dupilumab can be used with or without topical corticosteroids. Topical calcineurin inhibitors may be used, but should be reserved for problem areas only, e.g. face, neck, intertriginous and genital areas. Consider discontinuing treatment in patients who have shown no response after 16 weeks. AD Children(6-11y/o): Body weight 15 kg – <60 kg – initial dose of 300 mg on Day 1 follow by 300 mg on Day 15, then 300 mg every 4 weeks. Bodyweight ≥60 kg - same dosage as adults. The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg – <60 kg based on physician's assessment. *Asthma:* Initial dose of 400 mg, followed by 200 mg every other week. For patients with severe asthma and on oral corticosteroids or with severe asthma and co-morbid moderate-to-severe AD or adults with co-morbid severe CRSwNP- initial dose of 600 mg, followed by 300 mg every other week. Patients receiving concomitant oral corticosteroids may reduce steroid dose gradually once clinical improvement with dupilumab has occurred. The need for continued dupilumab therapy should be considered at least annually as determined by a physician. If a dose is missed, administer it asap and thereafter, resume dosing at the regular scheduled time. **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Safety and efficacy in children <6 years or <15 kg not been established. Not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm or status asthmaticus. Do not discontinue corticosteroids abruptly upon start of dupilumab. Reduction should be gradual and performed under supervision of a physician; it may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy. Biomarkers of type 2 inflammation may be suppressed by systemic corticosteroid use. If systemic hypersensitivity reaction occurs, discontinue dupilumab and initiate appropriate therapy. Be alert to vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in patients with eosinophilia. Treat pre-existing helminth infections before initiating dupilumab. If patients become infected while receiving dupilumab and do not respond to anti-helminth treatment, discontinue dupilumab until infection resolves. Patients who develop conjunctivitis and keratitis that does not resolve following standard treatment should undergo ophthalmological examination. AD patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Do not give live and live attenuated vaccines concurrently with dupilumab. Patients should be brought up to date with immunisations before starting dupilumab. **Drug Interactions:** Immune responses to TdaP vaccine and meningococcal polysaccharide vaccine were assessed. Patients receiving dupilumab may receive concurrent inactivated or non-live vaccinations. **Pregnancy and lactation:** Should be used during pregnancy only if potential benefit justifies potential risk to foetus. Unknown whether dupilumab is excreted in human milk or absorbed systemically after ingestion. Decision must be made whether to discontinue breast-feeding or dupilumab taking into account benefit of breast feeding for the child and benefit of therapy for the woman. **Undesirable effects:** Most common adverse reactions reported- injection site reactions, conjunctivitis, oral herpes and eosinophilia. Safety profile observed in adolescents consistent with that seen in adults. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 2 x 300 mg/2 ml in pre-filled syringe with needle shield, 2 x 200 mg/1.14 ml in pre-filled syringe with needle shield. **Legal Classification:** Part 1, First & Third Schedules Poison ***Full prescribing information is available upon request.*** API-HK-DUP-22.06

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**Sanofi Hong Kong Limited**
1/F & SECTION 212 on 2/F, AXA SOUTHSIDE, 38 WONG CHUK HANG ROAD, WONG CHUK HANG, HONG KONG
Tel: (852) 2506 8333 Fax: (852) 2506 2537

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