Hong Kong College of Paediatricians

30th Anniversary Scientific Meeting cum HM Lui Memorial Fund 20th Anniversary Symposium

4th – 5th December 2021

30th Anniversary Scientific Meeting cum
HM Lui Memorial Fund 20th Anniversary Symposium

	Day 1 (4 December 2021) Saturday	Day 2 (5 December 2021) Sunday
Time:	11:00 am – 6:00 pm	11:30 pm – 5:35 pm
Format:	**Hybrid**	**Online only**
	(Run Run Shaw Hall of HKAM and via Zoom)	(via Zoom)
CME points*:	**6 Points**	**6 Points**
Programme:		
	Two sponsored lunch symposia	*Two sponsored lunch symposia*
	(11:30 am – 1:15 pm)	*(12:00 noon – 1:20 pm)*
	Symposium on	*Symposium on*
	"Training and Preparing Future Paediatricians"	*"COVID-19 in Children: Vaccines and Beyond"*
	(1:35 pm – 3:15 pm)	*(1:35 pm – 3:15 pm)*
	20th Anniversary Symposium of	*Symposium on*
	HM Lui Memorial Fund	*"What the Future Holds for our Children"*
	(3:30 pm – 5:45 pm)	*(3:30 pm – 5:20 pm)*

Details of the programme:

Click for details of 30th ASM

Pre-registration:

https://online.hkam.org.hk/form/pd1204

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All College Fellows, Members, Associates and Guests are Welcome

CME Credits:
Hong Kong College of Paediatricians: **maximum 6 points (Category A) per day**
Hong Kong College of Physicians: **2 points (passive) per day**
Hong Kong College of Family Physicians: **pending**
MCHK CME Programme for Non-Specialists: **5 points (passive) on 4 Dec; 3 points (passive) on 5 Dec**

1) *** Instructions for CME Registration**
PRE-REGISTRATION for on-line attendance is now required per HKAM-MCHK Guideline – CME registration slides will be displayed online: (i) before the programme starts (pre-registration), (ii) at the afternoon break, and (iii) after the end of the programme (i.e. a total of **THREE** Google Forms) on each day. On each slide, there will be QR code and URL link leading to the unique Google Form that attendants need to complete and submit for CME accreditation.
< 1 point will be obtained when **ONE** Google Form is submitted, **3 points** when **TWO** Google Forms are submitted, and 6 points *only* when **ALL THREE** Google Forms are submitted >
Colleagues attending the meeting physically on 4 December will sign on the ATTENDANCE RECORD placed outside the venue.
2) Registration for **non-Academy Fellows** who wish to claim CME credits under **HKAM /MCHK CME Programme for Non-Specialists**
i) Pre-registration is required with payment of $100 via bank transfer to Hong Kong College of Paediatricians account (HSBC A/C No: 024-262-370000-007] and email the bank payment slip to College at lily.lin@paediatrician.org.hk not later than **29 November 2021.**
ii) Only fully paid registrants (non-HKAM Fellows) will receive HKAM's MCHK CME credits for Non-specialists.
[The above is NOT applicable to College Fellows, Members, Associates & Invited Guests.]
3) **Cancellation**: Scientific meeting will be cancelled if HK Observatory has issued Typhoon Signal No.8 or Black Rainstorm Warning two hours before the meeting.

Hong Kong College of Paediatricians
30th Anniversary Scientific Meeting cum HM Lui Memorial Fund 20th Anniversary Symposium

4th December 2021 (Saturday) | 11:00- 18:00
Run Run Shaw Hall, HK Academy of Medicine Jockey Club Building

HYBRID MODE

Time	Programme / Topic	Speaker
11:00 – 11:30	**Registration**	
11:30 – 11:45	**Welcome**	Dr Winnie Wing Yee TSE
	Lunch Symposium *(Gold Sponsor – Abbott Laboratory Limited)* Chairpersons: Dr Nai Chung FONG and Dr Yuen Yu LAM	
11:45 – 12:15	In Vitro Activity and PK/PD Parameters of Macrolides and Why it Matters for Therapy of Respiratory Tract Infections	Dr Ross DAVIDSON
12:15 – 12:17	**Advertisement video by Thermo Fisher Scientific**	
12:17 – 12:25	**Break**	
	Lunch Symposium *(Platinum Sponsor – GlaxoSmithKline)* Chairpersons: Prof Yiu Fai CHEUNG and Dr Polly Po Ki HO	
12:25 – 13:15	COVID, Influenza, and Meningitis	Prof Robert BOOY
13:15 – 13:35	**Lunch Break**	
	Symposium A – Theme "Training and Preparing Future Paediatricians" Chairpersons: Dr Winnie Wing Yee TSE and Dr Shun Ping WU	
13:35 – 13:55	What is Meant by a 'Good Paediatric Training Programme'?	Dr Jonathan DARLING
13:55 – 14:15	Preparing Future Paediatricians to Meet the Changing Challenges	Prof Lee Savio BEERS
14:15 – 14:35	Assessment is Important, but How?	Prof Hui Kim YAP
14:35 – 14:50	Paediatric Training Curriculum Review in Hong Kong	Dr Shun Ping WU
14:50 – 15:15	Panel discussion and Q & A	Panelist: Prof Albert Martin LI Panelist: Prof Wing Hang LEUNG
15:15 – 15:30	**Break**	
	HM Lui Memorial Fund 20th Anniversary Symposium *(Gold Sponsor – Providence Foundation Limited)* Chairpersons: Prof Simon LAM, Dr Janice Chin Ying CHOW and Dr Gerry Man Fung YEUNG	
15:30 – 17:35	**Opening speech**	Dr Arthur Ling Sing LUI
	Experience of Training Chinese Paediatricians from Other Provinces in Pediatric Hepatology	Prof Jianshe WANG

Name/Year	Title and Place/Subspecialty of Training
Dr Chung Mo CHOW (2007-08)	Paediatric Gastrointestinal Endoscopy: Hong Kong Experience *(Hepatology at Paediatric Liver Centre, King's College Hospital, London, UK)*
Dr Sharon Tsui Hang FUNG (2013)	Recent Advances in the Treatment of Paediatric Neuromuscular Disorders *(Neurology at Great Ormond Street Hospital for Children, London, UK)*
Dr Dennis Tak Loi KU (2014)	Neuro-oncology Training in SickKids: a Box of Unexpected Chocolates *(Neuro-oncology in Hospital for Sick Children, Toronto, Canada)*
Dr Lilian Po Yee LEE (2016)	Medically Complex Children Care - a Coordinated Model from Hospital to Community *(Division of Community and Societal Pediatrics, Department of Pediatrics, University of Florida, USA)*

	Dr Chantel Tsz Ying NG (2017-18)	Eczema and the Microbiome *(Paediatric and Genetic Dermatology Department, St John's Institute of Dermatology, St Thomas' Hospital, London, UK)*
	Dr Zita Gi Kay HUNG (2017-18)	Neonatal-Perinatal Medicine Training at The Stollery Children's Hospital *(Edmonton, Canada)* *(Neonatal-Perinatal Medicine Program, University of Alberta, Canada)*
	Closing speech	Prof Tai Fai FOK
17:35 – 17:45	**Closing remarks**	Prof Ting Fan LEUNG
17:45 – 18:00	**CME Registration**	
18:00 – 18:30	**Cocktail**	
18:30 – 19:00	**Annual General Meeting**	
19:00 – 20:00	**Fellows Conferment Ceremony**	
20:00 – 20:30	**Cocktail**	
20:30	**Celebration Dinner**	

Hong Kong College of Paediatricians
30th Anniversary Scientific Meeting

5th December 2021 (Sunday) | 11:30 - 17:35

ONLINE MODE ONLY

Time	Programme / Topic	Speaker
11:30 – 12:00	**Registration**	
12:00 – 12:10	**Welcome**	Prof Yiu Fai CHEUNG
	Lunch Symposium *(Gold Sponsor – Sanofi Hong Kong Limited)* Chairpersons: Dr David Chi Kong LUK and Dr Wilfred Cheuk Wa LEUNG	
12:10 – 12:40	The Role of Emerging Biologic Treatment for Atopic Dermatitis in Paediatric Patients	Prof Elaine C SIEGFRIED
12:40 – 12:42	**Advertisement video by Thermo Fisher Scientific**	
12:42 – 12:50	**Break**	
	Lunch Symposium *(Gold Sponsor – Fosun Pharma)* Chairpersons: Dr Ellis Kam Lun HON and Dr Karen Ka Yan LEUNG	
12:50 – 13:20	The Use of COVID-19 Vaccines in Children and Adolescents	Prof Robert W FRENCK
13:20 – 13:35	**Break**	
	Symposium B – Theme "COVID-19 in Children: Vaccines and Beyond" Chairpersons: Dr Ka Leung Daniel CHEUK and Dr Yat Sun YAU	
13:35 – 13:55	Public Health Policy for COVID-19 in Paediatric Population in Hong Kong	Prof the Honourable Sophia Siu Chee CHAN
13:55 – 14:15	Should We Vaccinate Children Against COVID-19?	Prof Nigel CURTIS
14:15 – 14:35	COVID-19 Vaccine Allergy: Who, When and What to Test?	Dr Agnes Sze Yin LEUNG
14:35 – 14:55	COVID-19 Infection in Children, HKSAR Situation	Dr Mike Yat Wah KWAN
14:55 – 15:15	Q & A	All speakers
15:15 – 15:30	**Break**	
	Symposium C – Theme "What the Future Holds for our Children" Chairpersons: Dr Chi Hang NG and Dr Carrie Ka Li KWOK	
15:30 – 15:55	Using Genomics to Transform Paediatric Care	Dr Ho Ming LUK
15:55 – 16:20	What Happens to Children with Obstructive Sleep Apnoea When Entering into Adulthood?	Dr Kate Ching Ching CHAN
16:20 – 16:45	Can a Child Grow Out of His or Her Allergies?	Prof Ting Fan LEUNG
16:45 – 17:10	Machine Learning and Artificial Intelligence for Paediatrics: Are We There Yet?	Prof Athimalaipet V RAMANAN
17:10 – 17:20	**Closing remarks**	Dr Nai Chung FONG
17:20 – 17:35	**CME Registration**	

30th ANNIVERSARY SCIENTIFIC MEETING

Dr Ross DAVIDSON
Director, Bacteriology, Queen Elizabeth II Health Sciences Centre
Departments of Medicine, Microbiology and Pathology
Professor, Dalhousie University, Halifax, Nova Scotia

Abbott

Dr Davidson completed his undergraduate and graduate education at the University of Manitoba and his fellowship training in medical microbiology at the University of Toronto and Mount Sinai Hospital. He is the director of Bacteriology at the Queen Elizabeth II Health Sciences Centre, Nova Scotia Health in Halifax, Canada, and is cross appointed in the Dept's of Medicine (infectious diseases) and Pathology & Laboratory Medicine. He is a professor at Dalhousie University and has academic appointments in Microbiology & Immunology, Medicine, and Pathology.

Dr Davidson's research interests are centered on the mechanisms of action and resistance to antimicrobials, the epidemiology of antimicrobial resistant pathogens and the management of respiratory tract infections. He also has an interest in the rapid diagnosis of infectious diseases through molecular and proteomic techniques. He has published more than 200 papers, book chapters, and conference abstracts.

ABSTRACT

In Vitro Activity and PK/PD Parameters of Macrolides and Why it Matters for Therapy of Respiratory Tract Infections

Respiratory tract infections are one of the leading reasons for which people seek medical attention and remain a significant cause of both morbidity and mortality. Specific treatment options are typically dependent on numerous factors such as the patient's acuity of disease, co-morbidities etc. Among these are the macrolides, a class of antimicrobials that have been successfully used to manage patients for decades. Similar to many therapeutic classes, there are several agents within the macrolide class. This seminar will discuss the accumulated data and the differences between the major agents of the macrolide class. Clarithromycin and azithromycin are second-generation macrolides established and widely used for treating a range of upper and lower respiratory tract infections. Extensive clinical trials data indicate that these drugs are highly effective in these applications and broadly comparable in their clinical and microbiological effectiveness. However, consideration of pharmacokinetic, metabolic, and tissue-penetration data, plus the findings of pharmacodynamic modeling, provide evidence that the long half-life and lower potency of azithromycin predispose this agent to select for resistant isolates. Indeed, novel pharmacodynamic parameters such as the "mutant-prevention concentrations " of clarithromycin and azithromycin also support these findings. Lastly, both animal modeling data and an examination of large-scale epidemiological data from Canada, support the view that these drugs differ materially in their propensity to promote resistance among bacterial strains implicated in common respiratory infections, and that clarithromycin may offer important advantages over azithromycin that should be considered when choosing a macrolide to treat these conditions.

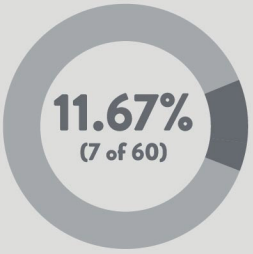
Abbott

Discover the benefits of clarithromycin in respiratory tract infections[1-3]

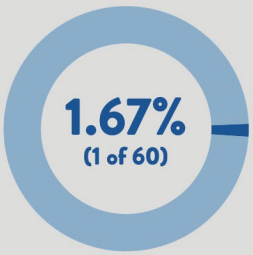
KLACID®
Clarithromycin

CLARITHROMYCIN REDUCES THE RISK OF REINFECTION COMPARED WITH AZITHROMYCIN[4]

Reinfection rate in children with upper or lower respiratory tract infections[4]



AZITHROMYCIN (n=60 evaluable patients)
Children treated with azithromycin experienced reinfection within 2-7 weeks of initiating treatment



CLARITHROMYCIN (n=60 evaluable patients)
Only one child treated with clarithromycin experienced reinfection 4 weeks after finishing treatment

DOSING REGIMEN:
CLARITHROMYCIN 15 mg/kg IN TWO DAILY DOSES FOR 7 DAYS
(n=80) AZITHROMYCIN 10 mg/kg OD FOR 3 DAYS (n=75)

Study design: prospective, randomised, open-label study. 264 patients (aged 6 months to 16 years) with upper or lower respiratory tract infections were randomised to receive clarithromycin 15 mg/kg in two daily doses for 7 days, azithromycin 10 mg/kg OD for 3 days, erythromycin 40 mg/kg in three daily doses for 7 days, roxithromycin 8 mg/kg OD for 7 days, or josamycin 40mg/kg in three daily doses for 7 days. Study objective: to compare the likelihood of five macrolides to promote resistance in the oral flora of children with respiratory tract infections.[2]

References: 1. Kyriazopoulou E, Sinapidis D, Halvatzis S, et al. Survival benefit associated with clarithromycin in severe community-acquired pneumonia: a matched comparator study. Int J Antimicrob Agents. 2020;55:105836. 2. Davidson RJ. In vitro activity and pharmacodynamic/pharmacokinetic parameters of clarithromycin and azithromycin: why they matter in the treatment of respiratory tract infections. Infect Drug Resist. 2019;12:585–596. 3. Spyridaki A, Raftogiannis M, Antonopoulou A, et al. Effect of Clarithromycin in Inflammatory Markers of Patients with Ventilator-Associated Pneumonia and Sepsis Caused byGram-Negative Bacteria: Results from a Randomized Clinical Study. Antimicrob Agents Chemother. 2012;56(7):3819-25. 4. Kastner U, Guggenbichler JP. Influence of macrolide antibiotics on promotion of resistance in the oral flora of children.Infection. 2001;29(5): 251–256.

Abbreviated Product Information:
Product name: Klacid Granules for Oral Suspension 125mg/5ml. Active ingredient: Clarithromycin. Indications:. Upper & lower resp tract infections, acute otitis media, skin & soft tissue infections, disseminated or localized mycobacterial infections. Dosage: Under 12yrs: 7.5 mg/kg bd, up to 500 mg bd in non-mycobacterial infections. Usual duration: 5-10 days. Renal impairment CrCl <30 mL/min Reduce by half. Mycobacterial infections 15-30 mg/kg in 2 divided doses. Method of administration: Reconstitute by adding water to the bottle label line. Take w/ or w/o meals, can be taken with milk. Contraindications: Known hypersensitivity to macrolides. Concomitant administration w/ astemizole, cisapride, pimozide, terfenadine & ergotamine or dihydroergotamine. History of QT prolongation or ventricular cardiac arrhythmias including Torsade de pointes. Renal or hepatic impairment who are taking P-glycoprotein or a strong CYP3A4 inhibitor. Concomitant administration w/ lovastatin or simvastatin. Special warnings and precautions for use: Impaired hepatic function & moderate to severe renal failure. Pseudomembranous colitis. Possibility of cross-resistance between clarithromycin & macrolides as well as lincomycin & clindamycin. H. pylori infection. Myasthenia gravis. Discontinue if signs & symptoms of hepatitis occurs (eg, anorexia, jaundice, dark urine, pruritus or tender abdomen). May impair ability to drive or operate machinery. Pregnancy & lactation. Interactions: Lovastatin, simvastatin, quinidine, disopyramide, digoxin, colchicine, ritonavir. Cisapride; macrolides; ergotamine, dihydroergotamine; CYP3A4 inducers; CYP450 inducers (eg, efavirenz, nevirapine, rifampicin, rifabutin, rifapentine); etavirine; fluconazole; ritonavir; antiarrhythmic drugs primarily metabolized by CYP3A4; omeprazole; sildenafil; taladafil; vardenafil; theophylline, carbamazepine; tolterodine; triazolobenzodiazepines (eg, alprazolam, midazolam, triazolam); colchicine; digoxin; zidovudine; phenytoin, valproate; atazanavir; itraconazole; saquinavir; verapamil. Fertility, pregnancy and lactation: Not advised without carefully weighing the benefits against risk. Effects on ability to drive and use machines: No data available. Potential AE for dizziness, vertigo, confusion and disorientation should be considered. Undesirable effects: Common: Diarrhea, vomiting, abdominal pain, dyspepsia, nausea, headache, taste perversion, Insomnia, liver function test abnormal, Rash, hyperhidrosis Revision date: Nov 2019

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HKG2210700

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Robert BOOY
Professor, Child & Adolescent Health,
Sydney Medical School, The Children's Hospital at Westmead

Professor Robert Booy is an infectious diseases paediatrician, with a Masters in epidemiology and a Doctorate in the epidemiology and prevention of Hib performed at the University of Oxford where he helped to form the Oxford Vaccine Group. He's an honours medical graduate of University of Queensland, trained at the Royal Children's hospital in Brisbane and spent 15 years in the UK, the last 5 years as Prof Child Health, University of London.

Professor Booy is a former Director of the National Centre for Immunisation Research and Surveillance, Australia and has supervised over 25 Doctorates and published over 300 papers.

ABSTRACT

COVID, Influenza, and Meningitis

Meningococcal disease caused by serogroups A B C W and Y can be routinely prevented by vaccination but universal childhood immunisation for all is not yet implemented in many developed, let alone poorer, countries, This is despite high levels of severe sequelae and death, related to diagnostic uncertainty and rapid progression of disease.

Serogroup B is the most prevalent in many parts of the world, and routine implementation programs in eg UK, Portugal and Italy have been successful.

The Covid pandemic has been deadly with 5 million recorded deaths in 2020/21 but the best estimates suggest over 15 million have perished.

Careful research has found that viral coinfections are rare, and indeed most viral respiratory pathogens, eg influenza and RSV, have actually been much less common in many developed countries, probably as a consequence of closed international borders and social distancing inter alia. Coinfection with Bacteria is also uncommon: S pneumoniae or S aureus are most common, in about 3% of hospitalised covid patients; hospital acquired confections included P aeruginosa, were also similarly uncommon. Despite the recently and increasingly documented strong association between influenza and secondary meningococcal sepsis, covid has rarely pre-disposed to secondary meningococcal sepsis. Vaccination programs need to integrate vaccines for new and old pathogens for maximum benefit.

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

30th ANNIVERSARY SCIENTIFIC MEETING

Dr Jonathan DARLING
Vice President, Education and Professional Development, RCPCH
Clinical Associate Professor, Paediatrics and Child Health and Medical Education, University of Leeds
Honorary Consultant, Leeds Children's Hospital

Jonathan Darling is Vice President for Education and Professional Development of the Royal College of Paediatrics and Child Health, UK. RCPCH plays a major role in postgraduate medical education, professional standards, research and policy.

Jonathan is Clinical Associate Professor in Paediatrics and Child Health and Medical Education at the University of Leeds, and Honorary Consultant General Paediatrician at the Leeds Children's Hospital at Leeds General Infirmary. He graduated in medicine from the University of Manchester in 1986, and then did paediatric training in Manchester, Oxford, London, Melbourne (Australia) and Leeds. During this period, he did an MD in international child health, which included a year in Tanzania. He became a consultant in 1998. He has been a Fellow of the UK Higher Education Academy since 2007.

He is Designated Doctor for safeguarding children for the Leeds Clinical Commissioning Group, and also Director of Student Support for the Leeds School of Medicine.

He has a particular interest in paediatric education, including valuing the voice of the child in assessment. He has been external examiner and reviewer for other UK medical courses. He is co-author of the paediatric textbook, Lecture Notes: Paediatrics.

ABSTRACT

What is Meant by a 'Good Paediatric Training Programme'?

How do we have a system where our trainees can thrive? What promotes this, what prevents it? I will discuss this in the wider context of 'good training' which includes elements such as learning outcomes, assessments, placements, supervisors, and quality assurance. I will suggest these are the 'head' approach to training – all essential and a part of a carefully designed system. Most systems are good at these, but having these in place does not equal thriving trainees. I want to suggest we need more of the 'heart' approach. To help us think this through, I will use the framework of the 'ABC' approach espoused by the 2019 GMC document 'Caring for Doctors, Caring for Patients' – Autonomy (and control); Belonging; and Competence. I will illustrate this with examples (such as use of Schwartz Rounds) to show that the environment 'heart' is just as important as the 'head' – we need both! This includes a new emphasis within our training cultures on compassionate leadership, psychological safety, and responsive and preventative support for wellbeing, including attention to our environment and relationships.

SHINGRIX
(ZOSTER VACCINE RECOMBINANT, ADJUVANTED)

Available Now

The ONLY shingles vaccine to demonstrate >90% efficacy in all age groups ≥ 50 years old.[1,2]

THE US CDC RECOMMENDS SHINGRIX AS THE PREFERRED VACCINE FOR THE PREVENTION OF SHINGLES[3]

☑ patients 50 years of age or older ☑ patients who previously received zoster vaccine (live)

Safety information[1]: SHINGRIX is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older. For intramuscular injection only. SHINGRIX is given as a 2-dose series. The second dose can be administered as soon as 2 months after the first dose (and if necessary, anytime between 2-6 months). Most frequently reported side effects include pain at the injection site, myalgia, fatigue and headache. Most of these reactions were not long-lasting.

CDC = Centers for Disease Control and Prevention

There are limited data on vaccination with SHINGRIX in patients previously vaccinated with ZVL: In a phase 3 study, humoral immunogenicity was non inferior among subjects previously vaccinated at least 5 years earlier with ZVL. No apparent safety differences were observed between study groups within 30 days post-dose 2 of SHINGRIX. Solicited local and systemic symptoms were similar between study groups: the levels of antibodies and immune cells that correlate with protection against shingles have not been clearly defined. There are no head-to-head clinical trials comparing the efficacy and safety of SHINGRIX to ZVL[1].

Abbreviated Prescribing Information

Name of the Medicinal Product: Shingrix vaccine powder and suspension for suspension for injection. Herpes zoster vaccine (recombinant, adjuvanted) **Qualitative and Quantitative Composition:** After reconstitution, 1 dose (0.5 ml) contains 50 micrograms of gE antigen adjuvanted with AS01B. Varicella Zoster Virus (VZV) glycoprotein E (gE) produced by recombinant DNA technology in Chinese Hamster Ovarian (CHO) cells. The GlaxoSmithKline proprietary $AS01_B$ Adjuvant System is composed of the plant extract *Quillaja saponaria* Molina, fraction 21 (QS-21) (50 micrograms) and 3-O-desacyl-4'-monophosphoryl lipid A (MPL) from *Salmonella minnesota* (50 micrograms) **Indications:** Shingrix is indicated for prevention of herpes zoster (HZ) and post-herpetic neuralgia (PHN), in adults 50 years of age or older. **Posology and Administration:** The primary vaccination schedule consists of two doses of 0.5 ml each: an initial dose followed by a second dose 2 months later. **Method of administration:** Intramuscular injection. **Contraindications:** Hypersensitivity to the active substances or to any component of the vaccine. **Special Warnings and Precautions for Use:** 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. As with other vaccines, vaccination with Shingrix should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a cold, should not result in the deferral of vaccination. As with any vaccine, a protective immune response may not be elicited in all vaccinees. Do not administer the vaccine intravascularly or intradermally. Subcutaneous administration is not recommended. Maladministration via the subcutaneous route may lead to an increase in transient local reactions. Shingrix should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following intramuscular administration to these subjects. Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints. **Interactions:** Shingrix can be given concomitantly with unadjuvanted inactivated seasonal influenza vaccine, 23-valent pneumococcal polysaccharide vaccine (PPV23) or reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa). The vaccines should be administered at different injection sites. **Fertility, pregnancy and Lactation: Pregnancy:** There are no data from the use of Shingrix in pregnant women. The effect on breast-fed infants of administration of Shingrix to their mothers has not been studied. **Undesirable effects:** lymphadenopathy, hypersensitivity reactions including rash, urticaria, angioedema, headache, gastrointestinal symptoms (including nausea, vomiting, diarrhoea and/or abdominal pain), myalgia, arthralgia, injection site reactions (such as pain, redness, swelling), fatigue, chills, fever, injection site pruritus, 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 7 Dec 2020 based on version HK052020(GDS03/EMA20200109). 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.

References: 1. GSK. SHINGRIX Hong Kong Prescribing Information GDS03. **2.** MSD. Zoster live, attenuated vaccine Product Circular. **3.** Centers for Disease Control and Prevention. Recommendations of the Advisory Committee on Immunization Practices for use of herpes zoster vaccines. MMWR. 2018 Jan;67(3):103-8.

PM-HK-SGX-ADVT-210001 (052023) Date of preparation: 21/6/2021

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30th ANNIVERSARY SCIENTIFIC MEETING

Prof Lee Savio BEERS, MD
President
American Academy of Pediatrics

Lee Ann Savio Beers, MD, began her one-year term as President of the American Academy of Pediatrics (AAP) on Jan. 1, 2021. Dr Beers is a Professor of Pediatrics and the Medical Director for Community Health and Advocacy at Children's National Hospital. She is the Founding Director of the DC Mental Health Access in Pediatrics program and Co-Director of the Early Childhood Innovation Network. She also oversees the Child Health Advocacy Institute's Community Mental Health CORE, a public-private coalition that serves as a catalyst to elevate the standard of mental health care for every young person in Washington DC.

She earned her Medical Degree from Emory University School of Medicine and completed a pediatric residency at the Naval Medical Center in Portsmouth VA. Prior to joining Children's National, she was a general pediatrician at the Naval Hospital in Guantanamo Bay, Cuba and the National Naval Medical Center in Bethesda, MD.

She received the Academic Pediatric Association 2019 Public Policy and Advocacy Award. She serves in a wide variety of leadership and advisory positions within the Washington DC community. Her clinical and research interests include adolescent pregnancy and parenting, the integration of mental health and pediatric primary care, the impact of adversity and stress on child well-being and advocacy education. She lives in Washington DC with her husband Nathaniel, and two children.

ABSTRACT

Preparing Future Paediatricians to Meet the Changing Challenges

The COVID-19 pandemic has had a profound effect on the emotional and behavioral health of children and families. This impact has been compounded by interruptions in school, health care, and community supports and resulted in a rise in suicidality, depression, and anxiety among young people, at the same time there is a lack of access to services.

The AAP recognizes that pediatricians are on the front line of mental health and have a unique opportunity to address this national mental health crisis. In her presentation, Dr. Beers will share how the American Academy of Pediatrics is training its pediatricians to identify and support youth at immediate risk as well as address the upstream factors and social drivers of health that cause and intensify disparities in risk.

She will also preview the AAP's Healthy Mental Development Initiative that seeks to promote child and family mental health by integrating mental health into pediatric primary care, equipping pediatricians to support healthy mental development in clinical practice, building diverse support structures for children and families, and creating a national culture of pediatric leadership to elevate and de-stigmatize discussions of mental health.

oral rotavirus vaccine

Rotarix

With only 2 oral doses

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Protect Infants from

genotypes of rotavirus with 2 dose schedule[1-7#]

THE ONLY Human Rotavirus Strain Vaccine

EARLY AND BROAD PROTECTION.

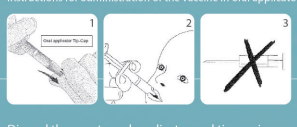
Safety information:
Rotarix should be administered orally and should not be injected under any circumstances.

[#] 6 studies were carried out in Asia, Europe, Latin America and Africa.[1-7]

References: 1. Rotarix Hong Kong Prescribing Information 2017. **2.** Vesikari T et al. Lancet 2007; 370:1757-1763. **3.** Phua KB et al. Vaccine 2009; 27:5936-5941. **4.** Steele D et al. BMC Infect Dis 2012; 12:213. **5.** Linhares AC et al. Lancet. 2008; 371:1181-1189. **6.** Yen, et al. J Infect Dis 2011; 204: 783–66. **7.** Patel, et al. BMJ 2013; 346: f3726.

Abbreviated Prescribing Information
Name of the Medicinal Product: ROTARIX oral suspension in pre-filled oral applicator. Rotavirus vaccine, live. Qualitative and Quantitative Composition: 1 dose (1.5 ml) contains not less than $10^{6.0}$CCID$_{50}$ of live attenuated human rotavirus RIX4414 strain produced on Vero cells. This product contains sucrose 1073mg. Therapeutic indications: Rotarix is indicated for the active immunisation of infants aged 6 to 24 weeks for prevention of gastro-enteritis due to rotavirus infection. The use of Rotarix should be based on official recommendations. Posology: The vaccination course consists of two doses. The first dose may be administered from the age of 6 weeks. There should be an interval of at least 4 weeks between doses. The vaccination course should preferably be given before 16 weeks of age, but must be completed by the age of 24 weeks. Rotarix should not be used in children over 24 weeks of age. Rotarix may be given with the same posology to preterm infants born after at least 27 weeks of gestational age. In clinical trials, spitting or regurgitation of the vaccine has rarely been observed and, under such circumstances, a replacement dose was not given. However, in the unlikely event that an infant spits out or regurgitates most of the vaccine dose, a single replacement dose may be given at the same vaccination visit. It is recommended that infants who receive a first dose of Rotarix complete the 2-dose regimen with Rotarix. Method of administration: Rotarix is for oral use only. Rotarix should under no circumstances be injected. Contraindications: Hypersensitivity to the active substance or to any of the excipients; hypersensitivity after previous administration of rotavirus vaccines; history of intussusception; subjects with uncorrected congenital malformation (such as Meckel's diverticulum) of the gastrointestinal tract that would predispose for intussusception; subjects with Severe Combined Immunodeficiency (SCID) disorder. Administration of Rotarix should be postponed in subjects suffering from acute severe febrile illness. The presence of a minor infection is not a contra-indication for immunisation. The administration of Rotarix should be postponed in subjects suffering from diarrhoea or vomiting. Warnings and Precautions: It is good clinical practice that vaccination should be preceded by a review of the medical history (especially with regard to previous vaccination and possible occurrence of undesirable events) and a clinical examination. There are no data on the safety and efficacy of Rotarix in infants with gastrointestinal illnesses or growth retardation. Administration of Rotarix may be considered with caution in such infants when, in the opinion of the physician, withholding the vaccine entails a greater risk. As a precaution, healthcare professionals should follow-up on any symptoms indicative of intussusception (severe abdominal pain, persistent vomiting, bloody stools, abdominal bloating and/or high fever) since data from observational safety studies indicate an increased risk of intussusception, mostly within 7 days after rotavirus vaccination (see section 4.8). Parents/guardians should be advised to promptly report such symptoms to their healthcare provider. For subjects with a predisposition for intussusception, see section 4.3. Asymptomatic and mildly symptomatic HIV infections are not expected to affect the safety or efficacy of Rotarix. A clinical study in a limited number of asymptomatic or mildly symptomatic HIV positive infants showed no apparent safety problems. Administration of Rotarix to infants who have known or suspected immunodeficiency should be based on careful consideration of potential benefits and risks. Excretion of the vaccine virus in the stools is known to occur after vaccination with peak excretion around the 7th day. Viral antigen particles detected by ELISA were found in 50% of stools after the first dose of Rotarix lyophilised formulation and 4% of stools after the second dose. When these stools were tested for the presence of live vaccine strain, only 17% were positive. In two comparative controlled trials, vaccine shedding after vaccination with Rotarix liquid formulation was comparable to that observed after vaccination with Rotarix lyophilised formulation. Cases of transmission of this excreted vaccine virus to seronegative contacts of vaccinees have been observed without causing any clinical symptom. Rotarix should be administered with caution to individuals with immunedeficient close contacts, such as individuals with malignancies, or who are otherwise immunocompromised or individuals receiving immunosuppressive therapy. Contacts of recent vaccinees should observe personal hygiene (e.g. wash their hands after changing child's nappies). The potential risk of apnoea and the need for respiratory monitoring for 48-72h 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 the vaccination is high in this group of infants, vaccination should not be withheld or delayed. A protective immune response may not be elicited in all vaccinees. The extent of protection that Rotarix might provide against other rotavirus strains that have not been circulating in clinical trials is currently unknown. Clinical studies from which efficacy data were derived were conducted in Europe, Central and South America, Africa and Asia. Rotarix does not protect against gastro-enteritis due to other pathogens than rotavirus. No data are available on the use of Rotarix for post-exposure prophylaxis. Rotarix should under no circumstances be injected. The vaccine contains sucrose as an excipient. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this vaccine. Adverse Reactions: In placebo-controlled clinical trials, in which Rotarix was administered alone (administration of routine paediatric vaccines was staggered), the incidence and severity of the solicited events, diarrhoea, vomiting, loss of appetite, fever, irritability and cough/runny nose, were not significantly different in the group receiving Rotarix when compared to the group receiving placebo. In a pooled analysis from placebo-controlled clinical trials including trials in which Rotarix was co-administered with routine paediatric vaccines, the following adverse reactions were considered as possibly related to vaccination: diarrhoea, flatulence, abdominal pain, intussusception, haematochezia, gastroenteritis with vaccine viral shedding in infants with Severe Combined Immunodeficiency (SCID) disorder, dermatitis, irritability, apnoea in very premature infants (≤28 weeks of gestation). Intussusception: Data from observational safety studies performed in several countries indicate that rotavirus vaccines carry an increased risk of intussusception, mostly within 7 days of vaccination. Up to 6 additional cases per 100,000 infants have been observed in the US and Australia against a background incidence of 33 to 101 per 100,000 infants (less than one year of age) per year, respectively. There is limited evidence of a smaller increased risk following the second dose. It remains unclear whether rotavirus vaccines affect the overall incidence of intussusception based on longer periods of follow-up. Safety in preterm infants: In a clinical study, 670 pre-term infants from 27 to 36 weeks of gestational age were administered Rotarix lyophilised formulation and 339 received placebo. The first dose was administered from 6 weeks after birth. Serious adverse events were observed in 5.1% of recipients of Rotarix as compared with 6.8% of placebo recipients. Similar rates of other adverse events were observed in Rotarix and placebo recipients. No cases of intussusception were reported. Pharmaceutical Particulars List of Excipients: Sucrose, Di-sodium Adipate, Dulbecco's Modified Eagle Medium (DMEM), Sterile water. Porcine Circovirus type 1 (PCV-1) material has been detected in Rotarix vaccine. PCV-1 is not known to cause disease in animals and is not known to infect or cause disease in humans. There is no evidence that the presence of PCV-1 poses a safety risk. Incompatibilities: This medicinal product must not be mixed with other medicinal products. Instructions for use and handling The vaccine is presented as a clear, colourless liquid, free of visible particles, for oral administration. The vaccine is ready to use (no reconstitution or dilution is required). The vaccine is to be administered orally without mixing with any other vaccines or solutions. The vaccine should be inspected visually for any foreign particulate matter and/or abnormal physical appearance. In the event of either being observed, discard the vaccine.

Instructions for administration of the vaccine in oral applicator:



1. Remove the protective tip cap from the oral applicator.
2. This vaccine is for oral administration only. The child should be seated in a reclining position. Administer orally (i.e. into the child's mouth towards the inner cheek) the entire content of the oral applicator.
3. Do not inject.

Discard the empty oral applicator and tip cap in approved biological waste containers according to local regulations. Abbreviated prescribing information prepared in Nov 2017 based on version number GDS14(EU-hk).
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 events reporting, please call GlaxoSmithKline Limited at 31898989.
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PM-HK-ROT-PSTR-210002 (09/2023) Date of preparation: 21/10/2021

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Hui Kim YAP
Professor, Department of Paediatrics, Yong Loo Lin School of Medicine, National University of Singapore

Research Interests:
Optimization of outcomes in children with chronic kidney disease
Immune mechanisms in glomerulonephritis
Immunogenetics of familial nephritis

Has published more than 100 articles in peer-reviewed journals.

Has been awarded several grants from the National Medical Research Council totalling more than 1 million dollars.

Won various awards including the National Kidney Foundation Gift of Life Award in 1996, Faculty Research Excellence Awards in 2005 and 2008, the National Medical Research Council National Outstanding Clinician Award in 2008, the Healthcare Humanity Award in 2012, Outstanding Asian Paediatrician Award from the Asian-Pacific Paediatric Association in 2012, and the Lee Foundation NHG-NUHS Life Time Achievement Award in 2013.

ABSTRACT

Assessment is Important, But How?

The goal of the structured programme in Pediatric Medicine is to provide broad educational exposure to the Resident culminating in specialist accreditation, in order that he/she attains competency to practise general paediatrics both in the community and hospital. Additionally, he/she is able to participate as a team member with the various paediatric subspecialists in providing comprehensive care to children with chronic and complex illnesses. Assessment helps us to ascertain whether the Resident has attained the desired competencies of the profession, and also to drive learning. Assessment can be formative or summative. The objectives of formative assessment include ensuring that the Resident has acquired the knowledge and skills to practise safely at the level expected, supporting the Resident in his/her learning and providing feedback for improvement, and identifying the Resident who may be struggling with competence, so that targeted support and remedial teaching can be provided. In order to design formative assessment tools, we must first be aware of the competencies that need to be achieved. These competencies can be categorized into Knowledge, Attitude and Practice and can be defined by activities known as Enstrusted Professional Activities. Assessment of these competencies (Competence Based Assessment) involve selecting milestone levels that best describe each Resident's current performance and attributes. Documentation of training and work experience is recorded in the training log book. In addition, the Resident also has to provide evidence of scholarly activity during the period of training, and this includes guideline writing, clinical practice improvement projects, and paper publication. Finally, summative assessment provides evidence of achievement for the purpose of making a judgment about Resident's competence or program effectiveness, and takes the form of the intermediate examination at Year 3 of Residency, namely the Masters of Medicine in Paediatrics, and the Paediatric Medicine Exit Examination at the end of Senior Residency.

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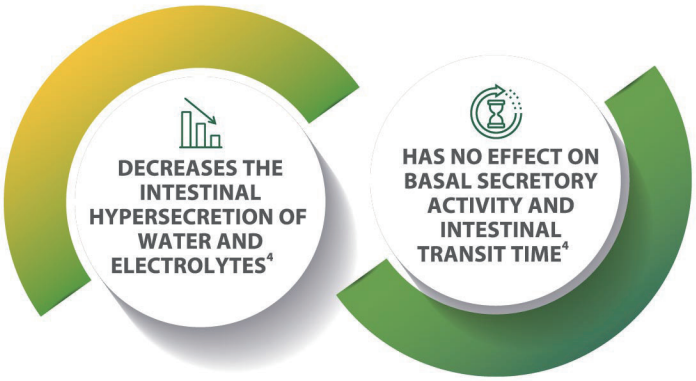

RACECADTRIL IS A NOVEL ANTI-SECRETORY AGENT[1] RECOMMENDED BY LEADING GUIDELINE (WGO & ESPGAN/ESPID) IN ACUTE DIARRHEA MANAGEMENT IN PEDIATRIC PATIENTS[2,3]

Available in 111 countries and to date 42 million infants and more than 73 million children have been treated[4]

WGO: World Gastroenterology Organistaion; ESPGHAN, European Society for Paediatric Gastroenterology Hepatology and Nutrition; ESPID, European Society for Paediatric Infectious Diseases;

Reference: 1. Canadian Paediatric Society. Position statement (N 2003-01) Treatment of diarrheal disease. Paediatric Child Health 2003;8:455–8. 2. World Gastroenterology Organisation Global Guidelines: Acute diarrhea in adults and children: a global perspective. 2012. 3. Guarino A, Ashkenazi S, Gendrel D, et al. European Society for Pediatric Gastroenterology, Hepatology, and Nutrition/European Society for Pediatric Infectious Diseases Evidence-Based Guidelines for the Management of Acute Gastroenteritis in Children in Europe: Update 2014. J Pediatr Gastroenterol Nutr 2014;59:132–152. 4. Hidrasec Company Core Data Sheet July 13, 2017

Abbreviated Product Information:

Product name: HIDRASEC Granules for Oral Suspension 10 mg. Active ingredient: Racecadotril. Indications: As a supplement to oral rehydration, symptomatic treatment of acute diarrhea in infants (from 1 - 30 months). Posology and method of administration: Oral route. Determine usual daily dose according to bodyweight on the basis of 1.5 mg/kg per dose, with one initial dose, then 3 doses spread over the day. In practice, 1 – 9mths (<9 kg): 1 sachet per dose; 9-30 months (~9-13 kg): 2 sachets per dose. Contraindications: Renal or hepatic impairment. Fructose intolerance, glucose and galactose malabsorption syndrome or sucrose-isomaltase deficiency. Warnings and precautions for use: offer oral rehydration for preventing and treating dehydration. Consider IV rehydration in severe vomiting or food refusal, severe or prolonged diarrhea. Consider the need for antimicrobials in infectious diarrhea. Interactions: Not applicable. Fertility, pregnancy and lactation: Not applicable. Effects on ability to drive and use machines: Not applicable. Undesirable effects: Not applicable. Overdose: Not applicable. Date of revision: Apr 2009

Product name: HIDRASEC Granules for Oral Suspension 30 mg. Active ingredient: Racecadotril. Indications: As a supplement to oral rehydration, symptomatic treatment of acute diarrhea in children (from 30 momths - 14 yrs). Posology and method of administration: Oral route. Determine usual daily dose according to bodyweight on the basis of 1.5 mg/kg per dose, with one initial dose, then 3 doses spread over the day. In practice, 30mths – 9yrs (~13-27 kg): 1 sachet per dose; >9 yrs (>27 kg): 2 sachets per dose. Contraindications: Renal or hepatic impairment. Fructose intolerance, glucose and galactose malabsorption syndrome or sucrose-isomaltase deficiency. Warnings and precautions for use: offer oral rehydration for preventing and treating dehydration. Consider IV rehydration in severe vomiting or food refusal, severe or prolonged diarrhea. Consider the need for antimicrobials in infectious diarrhea. Interactions: Not applicable. Fertility, pregnancy and lactation: Not applicable. Effects on ability to drive and use machines: Not applicable. Undesirable effects: Not applicable. Overdose: Not applicable. Date of revision: Apr 2009

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30th ANNIVERSARY SCIENTIFIC MEETING

Dr Shun Ping WU
Consultant Paediatrician, Queen Elizabeth Hospital
Chairman, Accreditation Committee, Hong Kong College of Paediatricians

Dr Wu graduated from the Faculty of Medicine, University of Hong Kong in 1989. He started his Paediatric training in 1991 at Queen Elizabeth Hospital, Hong Kong. He is now a Consultant Paediatrician at the hospital, specializing in Paediatric Neurology. He is one of the leading figures in the establishment of Paediatric Neurology Subspecialty training, and has been serving in the Paediatric Neurology Subspecialty Board since 2013. He started his service at the Hong Kong College of Paediatricians in 2016 when he joined the Accreditation Committee. He was elected a Council Member of the College in 2020. He is now the chairman of the Accreditation Committee. He has also been co-chairing the Working Group for Curriculum Review with the President of the College, Dr Winnie Tse, since April 2021. His vision is to work with all paediatric colleagues to bring about advancement in paediatric training in Hong Kong.

ABSTRACT

Paediatric Training Curriculum Review in Hong Kong

The College initiated a review of the paediatric specialty training curriculum three years ago. It coincided with the establishment of the Hong Kong Children's Hospital, but its progress was delayed due to the COVID-19 outbreak in 2020.

The review addresses the need to elevate the standard of our training and to endow our young doctors with different skill sets to suit the need of the community. It will tackle the many logistical issues in training, thereby making our training programme progressive and, at the same time, flexible.

Our present training program is heavily focused on hospital paediatrics. Training is assessed according to duration spent in an area and the volume of patient contacts. Formative assessment and an effective instrument for self-advancement and reflection are lacking.

A curriculum review has to cover the totality of the training experience. At its foundation will be a number of specified learning outcomes and key capabilities. Above it will be the details of the mode of training and the methods of formative and summative assessment. Detailed syllabuses of subspecialty areas are needed to spell out the intended scope of knowledge and skills. The new curriculum will shift our training and assessment to become competency-based.

The future curriculum will enable paediatrician trainees to undertake training that matches their aspirations. It will help identify trainee doctors that are struggling and give them timely guidance. It will enhance the development of all-round general paediatricians, but at the same time allow doctors to subspecialise if they so wish.

A new curriculum will need the support of all College fellows, members and associates. We will consult our colleagues, and closely work with our institutional partners in paediatric and child health service provision and the community stakeholders during its development.

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Elaine C SIEGFRIED, MD
Professor of Pediatrics and Dermatology
Director, Division of Pediatric Dermatology
Saint Louis University and Cardinal Glennon Children's Hospital
St. Louis, MO

SANOFI

Dr Siegfried is a professor of Pediatrics and Dermatology at Saint Louis University, board certified in Pediatrics, Dermatology and Pediatric Dermatology. She is an internationally recognized expert in the field and has authored more than 100 original papers, book chapters and abstracts and is a frequently invited lecturer. One of the proudest of her many academic pursuits is serving as a member the Board of Directors for the American Board of Dermatology. She has been repeatedly recognized as one of Woodward White's Best Doctors in America.

Dr Siegfried's current practice includes all aspects of caring for children with congenital and acquired skin problems. In addition to running a busy outpatient office practice, she acts as principle investigator in multiple industry-sponsored clinical trials, manages and provides consultation for pediatric emergency room and inpatients with skin disease.

ABSTRACT

The Role of Emerging Biologic Treatment for Atopic Dermatitis in Paediatric Patients

Atopic dermatitis (AD) is one of the most common skin disorders in children and the leading contributor to the global burden of skin disease. AD begins before the age of 5 years in more than 85% of patients and persists into adulthood in half the cases. In children with moderate-to-severe AD, skin lesions often involve a large body surface area (BSA), and the related pruritus, sleep deprivation, poor school performance, depression, and anxiety have a greater impact on quality-of-life (QOL) for patients and their caregivers than other common skin disorders.

Despite the chronic nature of AD, treatment in children is often limited to short-term topical corticosteroids (TCS), with topical calcineurin inhibitors as a second-line therapy. Guidelines discourage systemic corticosteroids owing to the risk of rebound after short-term treatment, unfavorable benefit-to-risk ratio, and multiple adverse events associated with their use. Eventually these treatments are offered only as a last resort for the most intractable cases, resulting in a large unmet need for children whose disease is inadequately controlled with topical therapy.

Dupilumab is a fully human, VelocImmune-derived monoclonal antibody that blocks the shared receptor component for IL-4 and IL-13. Dupilumab may improves treatment outcomes in children with severe atopic dermatitis inadequately controlled with topical corticosteroids, including signs, symptoms, and quality-of-life, with an acceptable safety profile. In this session, clinical data on the efficacy and safety profile of dupilumab for children with AD shall be discussed and elucidated with personal clinical experiences.

SHARED RESULTS

SHARED RELIEF

NOW APPROVED FOR PATIENTS WITH MODERATE-TO-SEVERE ATOPIC DERMATITIS AGED 12-17[1]

- First and only therapy that **specifically targets IL-4 and IL-13,** key drivers of persistent underlying Type 2 inflammation[1,2]
- **Rapid improvement** in lesion extent and severity, pruritus intensity and quality-of-life measures[1,3]
- Demonstrated a **consistent safety profile** in adults and adolescents[1]
  - No monitoring for organ toxicities required[1]
    - Most common adverse reactions were injection site reactions, conjunctivitis, blepharitis, and oral herpes[1]

Study Design[3]: A randomised, double-blind, parallel-group, phase 3 clinical trial conducted at 45 US and Canadian centres between March 21, 2017, and June 5, 2018. A total of 251 adolescents with moderate to severe AD inadequately controlled by topical medications or for whom topical therapy was inadvisable were included. Patients were randomised (1:1:1; interactive-response system; stratified by severity and body weight) to 16-week treatment with DUPIXENT®, 200mg (n = 43; baseline weight <60 kg), or DUPIXENT®, 300mg (n = 39; baseline weight ≥60 kg), every 2 weeks; DUPIXENT®, 300mg, every 4 weeks (n = 84); or placebo (n = 85). Main outcomes were proportion of patients with 75% or more improvement from baseline in Eczema Area and Severity Index (EASI-75) (scores range from 0 to 72, with higher scores indicating greater severity) and Investigator's Global Assessment (IGA) 0 or 1 on a 5-point scale (scores range from 0 to 4, with higher scores indicating greater severity) at week 16.

DUPIXENT® is indicated for the treatment of moderate-to-severe atopic dermatitis in patients aged 12 years or older who are candidates for systemic therapy.

References: 1. DUPIXENT® Hong Kong Prescribing Information. **2.** Gandhi NA et al. Nature Rev Drug Disc 2016; 15: 35–50. **3.** Simpson EL, Paller AS, Siegfried EC, et al. JAMA Dermatol 2019;156:44–56.

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. 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. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. AD adolescents: Body weight <60 kg- initial dose of 400 mg (two 200mg 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. 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- 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 <12 years 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 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:** AD: Most common adverse reactions reported- injection site reactions, conjunctivitis, blepharitis and oral herpes. Safety profile observed in adolescents consistent with that seen in adults. Asthma: Most common adverse reaction reported- injection site erythema. For other undesirable effects, please refer to the full prescribing information. **Preparation:** 2 x 300mg/2ml in pre-filled syringe with needle shield, 2 x 200mg/1.14ml 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-20.05

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DUPIXENT® (dupilumab)
LONG-TERM CONTROL

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Robert W FRENCK
Professor of Pediatrics, Division of Infectious Diseases
Director, Center for Vaccine Research
Cincinnati Children's Hospital

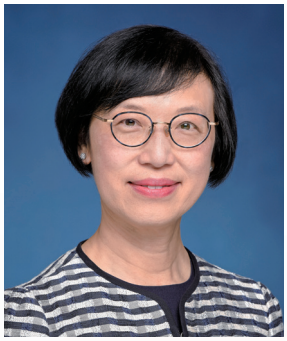
Robert W. Frenck, Jr, MD, received his undergraduate degree from the Univ. of Calif at San Diego in 1977 followed by his doctor of medicine degree from the University of Texas Health Science Center at Houston in 1981. He trained at the National Naval Medical Center in Bethesda, Maryland completing his pediatric residency in 1984. After 3 years as a general pediatrician at the US Naval Hospital, Japan, he entered pediatric infectious disease fellowship training at the University of Texas Health Science Center at Houston which he completed in 1990. After a 27 year career, Dr Frenck retired from the Navy and joined Cincinnati Children's Hospital (CCHMC) in 2006. Dr. Frenck is board-certified in both pediatrics and infectious diseases. Dr Frenck maintains an active research portfolio including therapeutic and vaccine clinical trials with special interest in enteric diseases. He has published over 140 articles in the peer-reviewed literature including 8 articles on COVID-19 vaccine clinical trials. Dr Frenck is a Professor of Pediatrics in the Division of Infectious Diseases at Cincinnati Children's Hospital and is the Director for their Center for Vaccine Research.

ABSTRACT

The Use of COVID-19 Vaccines in Children and Adolescents

Since December 2019, the SARS-Corona Virus 2 (commonly referred to as COVID-19) has had a catastrophic economic, social and medical impact on the world. While social distancing, good hand hygiene and masking can decrease the risk of COVID-19 transmission, it rapidly was determined that vaccines would be necessary to contain the pandemic. Within a few months of the original outbreak, the virus was identified, sequenced and potential vaccine targets identified. Due to the dire need of rapidly developing a vaccine, multiple approaches were evaluated including live attenuated and killed viral vaccines as well as protein based, adenoviral vectored and mRNA vaccines. The hope was to identify at least one vaccine with an efficacy of at least 50%. Remarkably, numerous vaccines have progressed through clinical trials all demonstrating efficacy above 70% and some having efficacy as high as 95%. The success of the vaccine clinical trials in adults have allowed trials to be conducted in children as young as 6 months of age. This talk will focus on the COVID-19 clinical trials that have been conducted in children and the importance of expanding COVID-19 vaccination to the general population of children.

30th ANNIVERSARY SCIENTIFIC MEETING



Prof Sophia Siu Chee CHAN, JP
Secretary for Food and Health
Government of the Hong Kong Special Administrative Region

Professor CHAN was appointed as Secretary for Food and Health on 1 July 2017. She was Under Secretary for Food and Health during 2012-2017 and participated in and responsible for policy formulation and promotion. Before joining the Government, Professor CHAN was a Professor in Nursing, Head of the School of Nursing and Director of Research at the University of Hong Kong (HKU). She was also an Assistant Dean of the Li Ka Shing Faculty of Medicine of HKU.

Having trained in and practised general and paediatric nursing in Hong Kong and London, she read her Master of Education at the University of Manchester, Master of Public Health at the Harvard School of Public Health, and completed her doctoral studies at the HKU. Subsequently, she focused on teaching, research and administration in academia. Professor CHAN's research is internationally recognised; she is awarded a Fellow of the Faculty of Public Health (through distinction), Royal College of Physicians of United Kingdom (FFPH (RCP)(UK)), and is the first nurse in Hong Kong being awarded the Fellow of the American Academy of Nursing (FAAN). Her paedagogy has been recognised by the award of the Faculty Teaching Medal in 2005 and the Outstanding Teaching Award in 2009, one of the highest honour for teaching achievements conferred by HKU.

Professor CHAN is one of the leading nurse scientists and her research specialises in public health, management of tobacco dependency and prevention of second hand smoke exposure in children, and proposes novel insights. Her team of investigators was one of the top funded researchers, and she published extensively in international journals on nursing, tobacco control, and public health. She consults widely nationally and internationally and has represented the University and the Food and Health Bureau in international meetings and invited by the World Health Organization to provide advice and leadership on their public health and tobacco control initiatives.

ABSTRACT

Public Health Policy for COVID-19 in Paediatric Population in Hong Kong

The **FIRST AND ONLY** asthma biologic to inhibit IL-4 and IL-13 signaling

AN ADD-ON MAINTENANCE TREATMENT FOR PATIENTS (12+ YEARS) WITH **INADEQUATELY CONTROLLED SEVERE ASTHMA** WITH TYPE 2 INFLAMMATION[1]

A CLEAR PATH TO ASTHMA CONTROL

NOW AVAILABLE

UP TO 72% REDUCTION
SIGNIFICANT EXACERBATION REDUCTION
in annualized severe exacerbations at Week 24 with DUPIXENT 200 mg Q2W + SOC vs placebo + SOC (*P*=0.0003)[1]

200 mL IMPROVEMENT
RAPID AND SUSTAINED IMPROVEMENT IN LUNG FUNCTION
at Week 52 with DUPIXENT 200 mg Q2W + SOC vs placebo + SOC (*P*<0.001)[3]

86% OF PATIENTS
REDUCED OR NO INCREASE IN THEIR OCS DOSE
by Week 24 with DUPIXENT 300 mg Q2W + SOC vs 68% with placebo + SOC (P<0.001)[2]

UP TO 75% OF PATIENTS
HIGH RESPONDER RATE
in Asthma Control Questionnaire measures of **sleep, activity limitations, and breathing**[1]

SELF-INJECTABLE
Convenient subcutaneous injection[1]

LIBERTY ASTHMA VENTURE Study Design[2]: 210 patients were randomly assigned with oral glucocorticoid-treated asthma to receive add-on DUPIXENT (at a dose of 300 mg) or placebo every 2 weeks for 24 weeks. After a glucocorticoid dose-adjustment period before randomization, glucocorticoid doses were adjusted in a downward trend from week 4 to week 20 and then maintained at a stable dose for 4 weeks. The primary end point was the percentage reduction in the glucocorticoid dose at week 24. Key secondary end points were the proportion of patients at week 24 with a reduction of at least 50% in the glucocorticoid dose and the proportion of patients with a reduction to a glucocorticoid dose of less than 5 mg per day. Severe exacerbation rates and the forced expiratory volume in 1 second (FEV_1) before bronchodilator use were also assessed.

LIBERTY ASTHMA QUEST Study Design[3]: 1902 patients who were 12 years of age or older with uncontrolled asthma were randomly assigned in a 2:2:1:1 ratio to receive add-on subcutaneous DUPIXENT at a dose of 200 or 300 mg every 2 weeks or matched-volume placebos for 52 weeks. The primary end points were the annualized rate of severe asthma exacerbations and the absolute change from baseline to week 12 in the forced expiratory volume in 1 second (FEV_1) before bronchodilator use in the overall trial population. Secondary end points included the exacerbation rate and FEV_1 in patients with a blood eosinophil count of 300 or more per cubic millimetre. Asthma control and DUPIXENT safety were also assessed.

EOS, eosinophils; FeNO, fractional exhaled nitric oxide; ICS, inhaled corticosteroid ; OCS, oral corticosteroid; Q2W, once every 2 weeks; SOC, standard of care.

References: 1. DUPIXENT Summary of Product Characteristics. May 2020. **2.** Rabe KF, Nair P, Brusselle G, et al. Efficacy and safety of dupilumab in glucocorticoid-dependent severe asthma. N Engl J Med. 2018;378(26):2475-2485. **3.** Castro M, Corren J, Pavord ID, et al. Dupilumab Efficacy and Safety in Moderate-to-Severe Uncontrolled Asthma. N Engl J Med. 2018;378(26):2486-2496.

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. 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. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week. AD adolescents: Body weight <60 kg- initial dose of 400 mg (two 200mg 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. 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- 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 <12 years 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 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:** AD: Most common adverse reactions reported- injection site reactions, conjunctivitis, blepharitis and oral herpes. Safety profile observed in adolescents consistent with that seen in adults. Asthma: Most common adverse reaction reported- injection site erythema. For other undesirable effects, please refer to the full prescribing information. Preparation: 2 x 300mg/2ml in pre-filled syringe with needle shield, 2 x 200mg/1.14ml 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-20.05

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DUPIXENT® (dupilumab) Injection
200mg · 300mg

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Nigel CURTIS
Professor of Paediatric Infectious Diseases, University of Melbourne
Head of Infectious Diseases, Royal Children's Hospital Melbourne

Professor Nigel Curtis is a paediatric infectious diseases physician and clinician scientist. He is the leader of the Infectious Diseases Research Group at the Murdoch Children's Research Institute, Professor of Paediatric Infectious Diseases at the University of Melbourne and Head of Infectious Diseases at The Royal Children's Hospital Melbourne.

Prof Curtis did his undergraduate medical degree at the University of Cambridge and clinical training at St Mary's Medical School, University of London. He undertook his laboratory training at Imperial College London St Mary's Campus, where he completed a PhD investigating the role of bacterial superantigen toxins in Kawasaki disease and in staphylococcal and streptococcal toxic shock syndrome. His specialist training in infectious diseases included working at the Great Ormond Street Hospital for Sick Children and a Fellowship at the British Columbia Children's Hospital. He has also worked for periods in The Gambia, Zimbabwe and South Africa.

Prof Curtis' research focuses on improving the diagnosis, treatment and prevention of infectious diseases in children, combining clinical research and trials with laboratory immunology studies. His current research interests focus on the innate and cellular immune response to BCG vaccine, as well as the immunodiagnosis of childhood TB (or not TB). He leads a multidisciplinary research team comprising clinicians, research nurses, laboratory scientists, PhD and other students.

He is the recipient of an NHMRC Investigator Award and has been an investigator on grants totalling more than thirty-five million dollars. He has published more than 360 papers.

He has been the lead investigator on numerous trials including The MIS BAIR Trial, a randomised controlled trial of neonatal BCG vaccination to investigate the immunomodulatory heterologous ('non-specific') effects of this vaccine, including its ability to prevent infections, allergic disease and asthma.

He is the Chief Principal Investigator of The BRACE Trial, a randomised controlled trial of BCG vaccination to reduce the impact of COVID-19 in healthcare workers that is recruiting over 10,000 participants in three continents worldwide.

ABSTRACT

Should We Vaccinate Children Against COVID-19?

Whether all healthy children under 12 years of age should be vaccinated against COVID-19 had been contentious. The balance of risks and benefits of COVID-19 vaccination in children is more complex than in adults as the relative harms from vaccination and disease are less well established in this age group.

Arguments for vaccinating this age group include protection against the direct effects of COVID-19, including complications such as PIMS-TS/MIS-C or long COVID, as well as indirect effects, such as helping reduce community transmission and preventing school closures.

This talk will outline the points to consider when weighing up the arguments for vaccination against the potential arguments against vaccinating this age group, including adverse effects, cost and vaccine supply issues.

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Privigen™: 10% liquid IVIg

Simple

- Ready-to-use 10% liquid human immunoglobulin for intravenous use (IVIg)
  - No warming or reconstitution necessary, saving preparation time and minimizing product waste
- 36-month room temperature (up to 25°C) storage
  - Saves refrigeration space

Sophisticated

- L-Proline-stabilized IVIg therapy
  - Contains no sugar (eg, sucrose or maltose)
  - Compared with other stabilizers, L-proline demonstrated better stabilizing activity and reduced dimer formation[1]
  - L-Proline also reduces immunoglobulin G (IgG) aggregation, minimizes fragmentation and prevents solution discoloration[1]
- Appropriate for a broad range of patient types
  - IgA ≤25 mcg/mL[2]
  - IgG purity ≥98%

Safe

- In a clinical trial for primary immunodeficiency syndromes, the proportion of Privigen™ infusions with temporally associated adverse events was 0.21, below the limit of 0.4 set by the USA Food and Drug Administration (FDA); 97% of adverse events were non-serious; 95% of 1,038 infusions were administered without premedication[3]
  - The most common adverse reactions (observed in >5% of subjects) were headache, fatigue, nausea, chills, back pain, pain, vomiting, pyrexia, sinusitis, cough, diarrhea and stomach discomfort

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

Hong Kong Privigen Abbreviated Product Information
Privigen™ Human normal immunoglobulin, solution for infusion (10%). **Indication:** Replacement therapy in primary immunodeficiency syndromes (PID), myeloma or chronic lymphocytic leukaemia with severe secondary hypogammaglobulinaemia and recurrent infections, and children with congenital AIDS and recurrent infections. Immunomodulation in immune thrombocytopenic purpura (ITP) in children or adults at high risk of bleeding or prior to surgical interventions to correct the platelet count, Guillain-Barré syndrome, Kawasaki disease. Allogeneic bone marrow transplantation. **Dosage:** Dosage regimen is dependent on the indication. In replacement therapy the dosage may be individualized depending on pharmacokinetic and clinical response. **Method of use:** Privigen should be infused intravenously. Initial infusion at rate of 0.3 mL/kg bw/hr for 30 minutes. If well tolerated, the infusion rate can be gradually increased to 4.8 mL/kg bw/hr. Maximum rate is 7.2 mL/kg bw/hr. **Adverse effects:** Adverse reactions may include cold shivers, headache, fever, vomiting, allergic reactions, nausea, joint pain, low blood pressure and mild backache. Rare adverse reactions include hypersensitivity reactions, anaphylactic shock, temporary skin reaction and haemolytic reactions. **Contraindications:** Hypersensitivity to the active substance or excipient and homologous immunoglobulins. Hyperprolinaemia. **Precautions:** Certain severe adverse reactions may be related to rate of infusion. In case of adverse reaction, either the rate of administration must be reduced or the infusion stopped. Caution for hypersensitivity, haemolytic anaemia, aseptic meningitis syndrome, thromboembolism and acute renal failure.

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References:
1. Bolli R, Woodtli K, Bärtschi M, Höfferer L, Lerch P. L-Proline reduces IgG dimer content and enhances the stability of intravenous immunoglobulin (IVIG) solutions. *Biologicals* 2010;38(1):150-157.
2. CSL Behring, Hong Kong Privigen™ Package Insert, June 2014.
3. Stein MR, Nelson RP, Church JA, et al; for the IgPro 10 in PID study group. Safety and efficacy of Privigen, a novel 10% liquid immunoglobulin preparation for intravenous use, in patients with primary immunodeficiencies. *Journal of Clinical Immunology* 2009; 29:137-144.

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Date of preparation: January 2021

30th ANNIVERSARY SCIENTIFIC MEETING

Dr Agnes Sze Yin LEUNG
Assistant Professor, Department of Paediatrics
The Chinese University of Hong Kong

Dr Agnes Leung is an Assistant Professor of the Department of Paediatrics, The Chinese University of Hong Kong, and a fellow of the Paediatric Immunology, Allergy and Infectious Diseases Subspecialty. She underwent overseas training at the Allergy Immunology Research Group at the Murdoch Children's Research Institute in Melbourne, Australia.

Dr. Leung, together with Prof. T.F. Leung run the Specialist Allergy and Infectious Diseases clinics at the Prince of Wales Hospital, which receives territory- wide referrals. Dr. Leung is currently the Junior leader and Board member of the Asia Pacific Academy of Pediatric Allergy, Respirology and Immunology, co-chair of the Junior Member Committee of the Asia Pacific Association of Allergy Asthma and Clinical Immunology, the World Allergy Organization (WAO) Anaphylaxis and Allergy Prevention Committee member, a council member of the Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases (HKSPIAID) and the Hong Kong Institute of Allergy (HKIA).

The main goal of Dr. Leung's research is to analyse the patterns, causes, and effects of allergic disorders, in particular food allergy, in the Asia-pacific region, in hope to provide effective preventive methods and safe treatment plans for patients with various allergic disorders. She is a key member in the publication of the territory's consensus statements on anaphylaxis and position statements on COVID-19 vaccine allergy safety issued by the WAO, HKIA and HKSPIAID/ HKCPaed.

ABSTRACT

COVID-19 Vaccine Allergy: Who, When and What to Test?

Since the first anaphylactic reactions after injection of the mRNA vaccines, studies on side effects, in particular, severe allergic events have been ongoing worldwide. Fear about the potential side effects of these new mRNA vaccines are the main contributor to a slow vaccine uptake rate. In response to concerns regarding the safety of receiving mRNA vaccines, the Hong Kong College of Paediatricians and the Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases have formulated a set of Joint Position Statements on BioNTech vaccination in adolescents with allergic diseases in June this year. The aim was to encourage adolescents aged 12-17 years old to receive the BioNTech vaccine while maintaining vaccine safety.

Here, we shall share with you our approach to cautiously administer COVID-19 vaccines in paediatric patients with perceived higher risk of COVID-19 vaccine-associated allergic reactions. The latest evidence on the risk of allergic reaction in the context of COVID-19 vaccination, the possible risk factors and the available tests will be discussed. We also propose solutions to overcome barriers to vaccinations as the potentials of viral propagation are risker outcomes than vaccination in a setting in which severe allergic reactions can be managed.

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Nimenrix™

Meningococcal groups A, C, W_{135} and Y conjugate vaccine

Early Protection[1*]

for Every Future Smile

The first and only conjugate vaccine in Hong Kong indicated for infants aged from 6 weeks against invasive meningococcal diseases caused by serogroups A, C, W_{135}, and Y.[1-3*]

*Nimenrix is indicated for infants aged from 6 weeks[1]

DOSAGE SCHEDULE[1]:

Infants from 6 weeks - < 6 months of ages — 2+1 Schedule

1st dose — 2 doses at least 2 months apart — 2nd dose — Booster dose

Booster dose at 12 months and at least 2 months after the 2nd dose

6 weeks - <6 months — 12 months

Infants from 6 - <12 months of ages — 1+1 Schedule

1st dose — Booster dose

Booster dose at 12 months and at least 2 months after the 1st dose

6 - <12 months — 12 months

Individuals from 12 months of age, adolescents, and adults — 1 dose only

1 dose

A single 0.5 mL dose of the reconstituted vaccine is used for immunization → No upper age limit

12 months — toddlers — adolescents — adults

Nimenrix™ may be given as a booster dose for individuals (aged ≥12 months) previously vaccinated with a conjugated or plain polysaccharide meningococcal vaccine[1]

Adapted from Hong Kong Prescribing Information of Nimenrix™

References: 1. Nimenrix™ (Meningococcal polysaccharide serogroups A, C, W-135 and Y conjugate vaccine) prescribing information. Pfizer Corporation Hong Kong Limited (Version Mar 2019). **2.** Meningococcal polysaccharide serogroups A, C, W_{135} and Y conjugate vaccine. MIMS.com Hong Kong. Drug Information. Accessed 8 Oct 2021. **3.** Drug Office. The Department of Health. The Government of the HKSAR. Search Drugs Database. Available at http://www.drugoffice.gov.hk/eps/drug/productSearchOneFieldAction. Accessed 8 Oct 2021.

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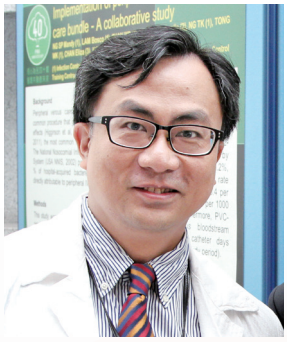
NIMENRIX™ ABBREVIATED PACKAGE INSERT **1. TRADE NAME:** NIMENRIX™ **2. PRESENTATION:** Powder and solvent for solution for injection. The powder or cake is white. The solvent is clear and colourless. **3. INDICATIONS:** Active immunisation of individuals from the age of 6 weeks against invasive meningococcal diseases caused by Neisseria meningitidis group A, C, W-135 and Y. **4.DOSAGE & ADMINISTRATION:** Primary immunization - Infants from 6 weeks to less than 6 months of age: two doses, each of 0.5 ml, should be administered with an interval of 2 months between doses. Infants from 6 months of age, children, adolescents and adults: a single 0.5 mL dose should be administered. Booster doses - After completion of the primary immunisation course in infants 6 weeks to less than 12 months of age, a booster dose should be given at 12 months of age with an interval of at least 2 months after the last Nimenrix™ vaccination. In previously vaccinated individuals 12 months of age and older, Nimenrix™ may be given as a booster dose if they have received primary vaccination with a conjugated or plain polysaccharide meningococcal vaccine. Nimenrix™ should be used in accordance with available official recommendations. Immunisation should be carried out by intramuscular injection only. In infants, the recommended injection site is the anterolateral aspect of the thigh. In individuals from 1 year of age, the recommended injection site is the anterolateral aspect of the thigh or the deltoid muscle. **5. CONTRAINDICATIONS:** Hypersensitivity to the active substances or to any of the excipients. **6. WARNINGS & PRECAUTIONS:** Nimenrix™ should under no circumstances be administered intravascularly, intradermally or subcutaneously. It is good clinical practice to precede vaccination by a review of the medical history (especially with regard to previous vaccination and possible occurrence of undesirable effects) and a clinical examination. Appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic event following the administration of the vaccine. Vaccination with Nimenrix™ should be postponed in subjects suffering from an acute severe febrile illness. The presence of a minor infection, such as a cold, should not result in the deferral of vaccination. Syncope (fainting) can occur following, or even before, any vaccination especially in adolescents as a psychogenic response to the needle injection. It is important that procedures are in place to avoid injury from faints. Nimenrix™ should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following an intramuscular administration to these subjects. It may be expected that in patients receiving immunosuppressive treatment or patients with immunodeficiency, an adequate immune response may not be elicited. Safety and immunogenicity have not been assessed in patients with increased susceptibility to meningococcal infection due to conditions such as terminal complement deficiencies and anatomic or functional asplenia. In these individuals, an adequate immune response may not be elicited. Nimenrix™ will only confer protection against Neisseria meningitidis group A, C, W-135 and Y. The vaccine will not protect against any other Neisseria meningitidis groups. A protective immune response may not be elicited in all vaccinees. Subjects previously vaccinated with a plain polysaccharide meningococcal vaccine and vaccinated with Nimenrix™ 30 to 42 months later had lower Geometric Mean Titres (GMTs) measured with rabbit complement serum bactericidal assay (rSBA) than subjects who had not been vaccinated with any meningococcal vaccine in the preceding 10 years. The clinical relevance of this observation is unknown. If a toddler is expected to be at particular risk of invasive meningococcal disease due to exposure to groups W-135 and Y, consideration may be given to administering a second dose of Nimenrix™ after an interval of 2 months. If an individual is expected to be at particular risk of exposure to group A and received a dose of Nimenrix™ more than approximately one year previously, consideration may be given to administering a booster dose. A booster dose might be considered in individuals vaccinated at toddler age remaining at high risk of exposure to meningococcal disease caused by groups A, C, W-135 and Y. Although an increase of the anti-tetanus toxoid (TT) antibody concentrations was observed following vaccination with Nimenrix™, Nimenrix™ does not substitute for tetanus immunisation. **7. INTERACTIONS:** In infants, Nimenrix™ can be given concomitantly with combined DTaP-HBV-IPV/Hib vaccines and with 10-valent pneumococcal conjugate vaccine. From age 1 year and above, Nimenrix™ can be given concomitantly with any of the following vaccines: hepatitis A (HAV) and hepatitis B (HBV) vaccines, measles - mumps - rubella (MMR) vaccine, measles - mumps - rubella - varicella (MMRV) vaccine, 10-valent pneumococcal conjugate vaccine or unadjuvanted seasonal influenza vaccine. In the second year of life, Nimenrix™ can also be given concomitantly with combined diphtheria - tetanus - acellular pertussis (DTaP) vaccines, including combination DTaP vaccines with hepatitis B, inactivated poliovirus or Haemophilus influenzae type b (HBV, IPV or Hib), such as DTaP-HBV-IPV/Hib vaccine, and 13-valent pneumococcal conjugate vaccine. Whenever possible, Nimenrix™ and a TT containing vaccine, such as DTaP-HBV-IPV/Hib vaccine, should be co-administered or Nimenrix™ should be administered at least one month before the TT containing vaccine. If Nimenrix™ is to be given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites. It may be expected that in patients receiving immunosuppressive treatment, an adequate response may not be elicited. **8. PREGNANCY:** Nimenrix™ should be used during pregnancy only when clearly needed, and the possible advantages outweigh the potential risks for the foetus. **9. LACTATION:** Nimenrix™ should only be used during breast-feeding when the possible advantages outweigh the potential risks. **10. SIDE EFFECTS:** Very common: appetite lost, irritability, drowsiness, headache, fever, swelling, pain and redness at injection site, fatigue. Common: diarrhoea, vomiting, nausea*, injection site haematoma*. Uncommon: insomnia, crying, hypoaesthesia, dizziness, pruritus, rash**, myalgia, pain in extremity, malaise, injection site induration, pruritus, warmth and anaesthesia. *Nausea and injection site haematoma occurred at a frequency of Uncommon in infants. **Rash occurred at a frequency of Common in infants. **Reference:** HK LPD version March 2019. **Date of preparation:** JAN 2020 **Identifier number:** NIME0120 **Hong Kong FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.**

PP-NIM-HKG-0038 Oct/2021

30th ANNIVERSARY SCIENTIFIC MEETING



Dr Mike Yat Wah KWAN
Consultant Paediatrician, Princess Margaret Hospital
Head of Paediatric Infectious Diseases Unit, Hospital Authority Infectious Disease Centre

Dr Mike Yat-Wah Kwan is the Consultant Paediatrician of the Department of Paediatrics and Adolescent Medicine and Head of the Paediatric Infectious Diseases Unit of the Hospital Authority Infectious Disease Centre at Princess Margaret Hospital. He is a Paediatric Immunology, Allergy and Infectious Diseases Subspecialist and Chairman of the Paediatric Immunology, Allergy and Infectious Diseases Subspecialty Board, Hong Kong College of Paediatricians. He is a member of the Hospital Authority Infectious Disease Centre Management Committee, the Central Committee of Infectious Diseases and Emergency Response and the Task Force on Clinical Management on Infection. Dr. Kwan is appointed as a member of the Expert Panel for the National Committee for the Certification of the Wild Poliovirus Eradication in Hong Kong, the Scientific Committee on Vaccine Preventable Diseases of the Centre for Health Protection, Department of Health. He is the Founding Council Member and the Past President of the Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases. He is the Standing Committee member representing Hong Kong SAR in the Asian Society for Pediatric Infectious Diseases. He is being elected as council member of the Hong Kong College of Paediatricians. He is also member of the College Subspecialty Board, College Training Subcommittee, Membership Subcommittee and Secretary of the Accreditation Committee of The Hong Kong College of Paediatricians. His research is focused on the epidemiology of infectious diseases, respiratory virus infections and vaccinology. He has authored and co-authored publications on paediatric SARS infection, avian influenza, influenza vaccine effectiveness, paediatric SARS-CoV2 infection and various papers and guidelines on other infectious disease topics. Currently Dr. Kwan is coordinating research in paediatric SARS-CoV2 infection, effectiveness of COVID-19 vaccine and adverse effects related to COVID-19 vaccine, etc with local and overseas partners.

ABSTRACT

COVID-19 Infection in Children, HKSAR Situation

Coronavirus disease 2019 (COVID-19) has spread to the world in a global scale and the World Health Organization declared the disease as a global pandemic on 11th March 2020. As of 28th October 2021, according to the World Health Organization (WHO), the COVID-19 pandemic has infected over 244,385,444 individuals across the world, resulting in 4,961,489 fatalities and significant disruption to regular activities and national economics. In Hong Kong Special Administrative Region, there were 1013 children hospitalized for paediatric COVID infections, which accounted for 8.2% of the total infected population. Children are found to be less symptomatic to SARS-CoV2 virus infection, however we identified a spectrum of clinical presentations including Paediatric Inflammatory Multisystem Syndrome Temporally Associated with SARS CoV-2 (PIMS-TS) and COVID Toes and long-term complications in childhood and adolescent COVID-19 infections. Since SARS-CoV2 is more transmissible, there will be more symptoms to be uncovered as the pandemic progresses. Moreover, we should pay attention to the asymptomatic children and adolescents who are potential sources of infection to the adults in the community. Comirnaty (BNT162b2 mRNA vaccine co-developed by BioNTech and Pfizer) was available for adolescents aged 12 and above in the territory since 14 June 2021. A diagnostic workflow was drafted to evaluate the clinical characteristics and laboratory parameters of each adolescent with symptoms and signs of pericarditis and / or myocarditis after Comirnaty vaccination. Apart from vaccination, mask wearing, social distancing and hand hygiene, the importance of adequate ventilation strategies at school or any enclosed space should be stressed to prevent airborne transmission of SARS-CoV2.

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Reference:
1. Reportlinker (2020). A White Paper To Understand The Market Structure Of Pediatric Pertussis Combination Vaccines. https://www.reportlinker.com/insight/wp-content/uploads/2020/11/201113_Market-study_on_Hexavalent_Vaccine_White_Paper.pdf?utm_medium=blog&utm_source=insight&utm_campaign=Sanofi2020&utm_content=report Accessed on 11Oct2021 (^2019 data)

Presentation: Suspension for injection in pre-filled syringe, diphtheria, tetanus, pertussis (acellular, component), hepatitis B (rDNA), poliomyelitis (inactivated) and Haemophilus influenzae type b, conjugate vaccine (absorbed). **Indications:** Hexaxim helps to protect against diphtheria, tetanus, pertussis, hepatitis B, poliomyelitis and serious diseases caused by Haemophilus influenzae type b. Hexaxim is given to children from six weeks of age. **Dosage:** Primary vaccination: either two injections given at interval of two months or three injections given at an interval of one to two months (at least four weeks apart). This vaccine should be used according to the local vaccination programme. Booster: After the first course of injections, a booster dose will be received, in accordance with local recommendations, at least 6 months after the last dose of the first course. For details of the dosage and administration, please refer to the full prescribing information. **Contraindications:** Allergic to any components of the vaccine listed in the package insert, or to glutaraldehyde, formaldehyde, neomycin, streptomycin or polymyxin B, or any other diphtheria, tetanus, pertussis, poliomyelitis, hepatitis B or Hib containing vaccines. History of encephalopathy within 7 days of a prior dose of a pertussis vaccine. Uncontrolled neurologic disorder or uncontrolled epilepsy. **Precautions:** Vaccination should be postponed if child has moderate or high temperature or an acute illness. Evaluation should be done by doctor before vaccination if child previously had Guillain-Barré syndrome or brachial neuritis after being given a vaccine containing tetanus toxoid. Patients with compromised immune system. Acute or chronic illness including chronic renal insufficiency or failure. Undiagnosed illness of the brain or epilepsy which is not controlled. **Interactions:** Hexaxim can be given at the same time as other vaccines such as pneumococcal vaccines, measles-mumps-rubella vaccines, rotavirus vaccines or meningococcal vaccines. When given at the same time with other vaccines, Hexaxim will be given at different injection sites. **Undesirable effects:** Very common: loss of appetite, crying, sleepiness, vomiting, pain, redness or swelling at the injection site, irritability, fever. Common: abnormal crying, diarrhea, injection site hardness. For uncommon, rare and very rare undesirable effects, please refer to the full prescribing information. **Storage:** Store in a refrigerator (2°C - 8°C). Do not freeze. Protect from light. **Preparation:** 1 syringe and 2 separate needles per box. **Legal Classification:** Part 1, First & Third Schedules Poison ***Full prescribing information is available upon request.***

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30th ANNIVERSARY SCIENTIFIC MEETING

Dr Ho Ming LUK
Consultant, Clinical Genetics Service Unit, Hong Kong Children's Hospital

Dr Ho-Ming Luk obtained his basic medical degree from the University of Hong Kong. He was trained in Paediatrics in Queen Mary Hospital and Genomic Medicine in Clinical Genetic Service, Department of Health Hong Kong and Guy's and St Thomas' Hospital UK, He is now working as Consultant in Clinical Genetics Service Unit of Hong Kong Children's Hospital, Hospital Authority. He is also the Clinical Lead in the Hong Kong Genome Project/Hong Kong Children's Hospital Partnering Center.

His main clinical activities and researches are the usage of cutting-edge technologies in diagnosis, management and prevention for prenatal, paediatric and adult genetic and genomic diseases. He has published more than 90 articles in local, regional and international peer viewed journals.

ABSTRACT

Using Genomics to Transform Paediatric Care

This talk will provide the update on the clinical application of genomic medicine in paediatric practice.

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References: 1. Cetraxal plus Summary of Product Characteristics. 2. Spektor Z, et al. AMA Otolaryngol Head Neck Surg 2017; 143(4): 341-349.

CETRAXAL PLUS Summary of Product Information
TRADE NAME: CETRAXAL PLUS (Ciprofloxacin 3mg, fluocinolone acetonide 0.25mg) **PRESENTATION & PACKING:** 0.25 mL (single-dose container) x 15's. **INDICATIONS:** Cetraxal Plus is indicated for the treatment of acute otitis media in adults & children > 6 months with tympanostomy tubes caused by ciprofloxacin-susceptible microorganisms. **DIRECTIONS FOR USE & DOSAGE:** Solution should be warmed before using by holding the ampoule in the hand for 1 or 2 minutes. **Adult, elderly, children ≥6 months** Instill contents of 1 single-dose container into the affected ear canal every 12 hours for 7 days. **CONTRAINDICATIONS:** Hypersensitivity to ciprofloxacin, fluocinolone acetonide, or any member of the quinolone class of antimicrobial agents. Viral infections of the external ear canal, including varicella & herpes simplex infections & fungal otic infections. **WARNINGS & PRECAUTIONS:** For auricular use only. Not for ophth use, inhalation or injection. Discontinue at the 1st appearance of skin rash or any other sign of hypersensitivity. May result in overgrowth of non-susceptible organisms, including bacterial strains, yeast & fungi. Corticosteroids may reduce resistance to, & aid in the establishment of bacterial, viral, or fungal infections; mask clinical signs of infection; or may suppress hypersensitivity reactions to substances in the product. Reports of visual disturbance. Pregnancy & lactation. Children <6 months. **ADVERSE REACTIONS:** Ear pain, ear discomfort, ear pruritus; dysgeusia. **INTERACTIONS:** Not recommended to use other ear prep concomitantly. If >1 ear prep needs to be administered, it is advised to administer them apart. Refer to the package insert for complete recommendation. **Full Prescribing Information is available upon request.**

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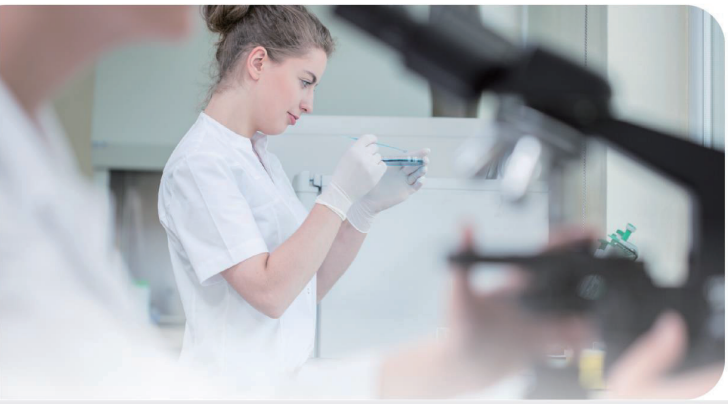

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PM-J-023-092021

30th ANNIVERSARY SCIENTIFIC MEETING

Dr Kate Ching Ching CHAN
Clinical Professional Consultant, Department of Paediatrics
The Chinese University of Hong Kong

Dr Kate Chan is currently a Clinical Professional Consultant at the Department of Paediatrics. She is also an Honorary Associate Consultant at the Department of Paediatrics, Prince of Wales Hospital and the Hong Kong Children's Hospital. She is a specialist in Paediatric Respiratory Medicine. Her research focuses on paediatric sleep disordered breathing (SDB), including its natural history, pathogenesis, diagnostic tools, complications, and personalised management to childhood SDB. She is also a board member of the International Pediatric Sleep Association, which is devoted to promote paediatric sleep medicine worldwide.

ABSTRACT

What Happens to Children with Obstructive Sleep Apnoea When Entering into Adulthood?

Obstructive sleep apnoea (OSA) is a common sleep disorder that affects all ages. The reported prevalence is 3%–5% in children. It is an important disease as it is associated with significant morbidities including neurobehavioural, cardiovascular and metabolic complications. Childhood and adult OSA share certain similarities in pathophysiology, namely anatomically narrow upper airway, increase in airway collapsibility and/or alterations of neuromuscular tone. However, they are also very distinct disease entities because of different aetiologies. Long-term follow up studies to evaluate the natural course and outcomes of childhood SDB are scarce. Understanding the natural history, risk factors associated with OSA persistence or incidence, and long term outcomes of childhood SDB can help predict disease course, prognosis, perform risk stratification and provide guidance in disease management. Through our 10-year follow-up of the Hong Kong Child Sleep Cohort, we found that a proportion of children with OSA, particularly female children, had complete resolution during transition to late adolescence or early adulthood. Childhood and adolescent OSA are distinct entities, with the latter more likely to correlate with adult disease. Obesity and male sex are consistent key risk factors for incident OSA in early adulthood. On the other hand, childhood moderate-to-severe OSA was found to be an independent risk factor for adverse blood pressure outcomes in early adulthood. Future studies should investigate whether timely OSA treatment would lessen one's risk of developing BP abnormalities, and if proven, targeting this modifiable childhood factor would be a way forward to reduce future cardiovascular disease burden.

30th ANNIVERSARY SCIENTIFIC MEETING

Prof Ting Fan LEUNG
Alice Ho Miu Ling Nethersole Charity Foundation Professor of Paediatrics,
Department of Paediatrics
Founding Director, Hong Kong Hub of Paediatric Excellence (HK HOPE)
The Chinese University of Hong Kong

Professor Leung is the Alice Ho Miu Ling Nethersole Charity Foundation Professor of Paediatrics in the Department of Paediatrics and Founding Director of Hong Kong Hub of Paediatric Excellence (HK HOPE) at The Chinese University of Hong Kong. He is also an honorary professor of the Peking Union Medical College Hospital and a visiting professor of the Central South University in the People's Republic of China. Internationally, Professor Leung is a Board Member of Asia Pacific Association of Allergy, Asthma and Clinical Immunology and immediate past secretary-general of the Asia Pacific Academy of Pediatric Allergy, Respirology and Immunology. Locally, he is Vice President of Hong Kong College of Paediatricians and Hong Kong Institute of Allergy as well as Immediate Past President of Hong Kong Society for Paediatric Immunology, Allergy and Infectious Diseases. Professor Leung published more than 380 peer-reviewed journal articles, and supervised seven postdoctoral fellows and 24 postgraduate students. His main research interests include natural history, novel diagnostics, genetics and host-microbe interactions of childhood allergic diseases.

ABSTRACT

Can a Child Grow Out of His or Her Allergies?

Allergic diseases consisting mainly of asthma, allergic rhinitis, eczema and food allergy are highly prevalent in toddlers and children. Epidemiological studies from International Study of Asthma and Allergy in Childhood reported that asthma, allergic rhinitis and eczema affected one-tenth, one-third and 15 percent of secondary schoolchildren, respectively. Our territory-wide kindergarten survey found that around eight percent of pre-school children had adverse food reactions, with the commonest food culprits being shellfish, hen's egg, peanut, cow's milk, fish and nuts. With the addition of objective allergen-specific IgE measurements, our collaborative study with EuroPrevall reported that 2-3 percent of primary schoolchildren suffered from probable food allergy. Shellfish was again the top food item causing such allergic manifestations. It is common clinical experience that many young allergic children outgrow their diseases by adolescents and early adulthood. Nonetheless, the predictors for such highly dynamic processes remain unclear especially in the Chinese population. For asthmatic children, there is limited data on their lung function trajectories in the long run. Our several ongoing prospective studies shed light on the natural history of asthma, eczema and food allergy. Especially for food allergy, different food items are known to have divergent evolutionary pattern throughout childhood. Allergies to cow's milk, hen's egg and soybean tend to resolve during the first five years of age while most children who are allergic to peanut, tree nuts, shellfish and fish have persistent food allergy. This presentation will introduce locally relevant data on the natural history as well as risk and protective factors for the resolution of different allergic diseases in children. *(funded by Research Impact Fund and General Research Fund of Research Grants Council, Health and Medical Research Fund, Hong Kong Institute of Allergy Research Grant and European Union Trilateral Research Grant)*

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References : 1. Galderma. Formulation claim. 2. Galderma. Data on file (RD.03.SPR.105653). 3. Galderma. Data on file (RD.03.SPR.105328). 4. Galderma. Data on file (DCC13U019). 5. Galderma. Data on file (DCC13K031GR1).

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30th ANNIVERSARY SCIENTIFIC MEETING

Prof Athimalaipet V RAMANAN
Professor of Paediatric Rheumatology
The University of Bristol

Athimalaipet V Ramanan is a consultant pediatric rheumatologist at the Bristol Royal Hospital for Children. He is the joint lead for research (Division of Women and Children) at the Bristol Royal Hospital for Children, and Professor of Paediatric Rheumatology at the University of Bristol.

Professor Ramanan is a medical advisor for Olivia's Vision. He is also Chair for the National Institute for Health Research Clinical Research Network: Children/Arthritis Research UK (ARUK) Paediatric Rheumatology Clinical Studies Group, and Associate Director for the UK Experimental Arthritis Treatment Centre for Children (JIA-Uveitis and Industry work streams). He was awarded the British Society of Rheumatology's Innovation in Clinical Practice Award in 2010. He was also awarded the University of Bristol Vice Chancellor's Health Impact award in 2017 and Royal College of Physicians/ NIHR CRN Award for outstanding contribution to research in 2018.

Professor Ramanan's has published >200 articles and numerous book chapters covering a variety of topics in the field of rheumatology. He is the Co-Editor of *Rheumatology* and Associate Editor for the *Archives of Diseases in Childhood*. He is also leading trials of Tocilizumab and Baricitinib in COVID-19 and part of the paediatric steering committee of the RECOVERY trial.

ABSTRACT

Machine Learning and Artificial Intelligence for Paediatrics: Are We There Yet?

The last decade has seen incredible technological advances in society which have also impacted medicine. Increasingly, technology has played a major role in medical care in the form of electronic medical records, digitisation of images and in the laboratory. Machine learning and AI are slowly entering the world of medicine with the most impact for now in fields of radiology and ophthalmology. In this talk I will focus on how Machine learning and AI can positively impact paediatrics. Certainly, paediatrics poses more challenges than adult specialities because of the huge variability with different stages of growth. It is important to look at AI as "augmenting" human intelligence rather than replacing it.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Prof Jianshe WANG
Professor in Pediatrics, Fudan University Shanghai

Jian-She Wang, MD, PhD, as a H. M. Lui scholar trained in pediatric hepatology in King's College Hospital London in March-October, 2003. He currently holds a Professor position of Pediatrics at Fudan University Shanghai Medical College. He is also the Chief of the Center for Pediatric Liver Disease, and Director of the Department for Infectious Disease at the Children's Hospital of Fudan University.

He is the former chair of pediatric hepatology committee of the Society of Infectious Diseases, Chinese Medical Association (CMA). He also works as the vice-chair of the infectious diseases committee of Chinese Pediatric Society, and the vice-chair of the inherited liver diseases committee of Chinese Society of Hepatology, CMA.

Dr. Wang received his medical degree in 1986 and his MSc in 1991 from the Zhengzhou University Medical College, China. He received his PhD from Fudan University in 2011. He was trained in Pediatrics in the Third Affiliated Hospital of Zhengzhou University from 1986-1988 and 1991-1998.

His research work is focused on inherited liver diseases. In particular, Dr. Wang's laboratory worked on understanding the disease spectra of childhood cholestasis and identified novel disease entities: MYO5B- associated cholestatic spectrum, USP53-associated cholestasis, ZFYVE19 disease, and RINT1 mutation caused fever-related recurrent liver failure in the past years. Dr Wang's team developed related mice models and is currently dedicated to decipher the mechanisms, explore the prognostic biomarkers, and test gene therapy for these newly identified cholestatic disorders.

ABSTRACT

Experience of Training Chinese Paediatricians from Other Provinces in Pediatric Hepatology

Prof Jian-She Wang, The Center for Pediatric Liver Diseases, Children's Hospital of Fudan University, Shanghai 201102

I received pediatric liver training with the support of HM LUI fellowship in King's College Hospital in 2003. The experience opened a new door for me to explore the mysterious pediatric liver diseases and gradually established my reputation in pediatric liver world. In return, in the Tenth Anniversary Symposium of HM LUI Memorial Fund, I proposed to train Chinese pediatricians from other provinces in pediatric hepatology in Shanghai and got active response from the HM LUI Memorial Fund.

After several visits by Prof. Nai-Kong Leung to Shanghai, the training program in Shanghai started to recruit trainee in the end of 2013. Totally 17 trainees were supported by the program, including two each from Xinjiang Uygur Autonomous Region (新疆維吾爾自治區) and Sichuan Province(四川省), One each from Shaanxi province (陝西省), Gansu Province (甘肅省), Shanxi Province (山西省), Shandong Province (山東省), Guizhou Province (貴州省), Chongqing (重慶市), Fujian Province (福建省), Guangdong Province (廣東省), Anhui Province (安徽省), Henan Province (河南省), Hunan Province (湖南省), Hubei Province (湖北省), and Jiangxi Province (江西省).

In the training, the trainees were exposed to clinic consultation and ward round, as well to various teaching courses and research programs. Some trainees even got their work published in major national or international scientific journals. All trainees highly evaluated the program and are grateful for the support from HM LUI Memorial Fund. During the teaching, I myself also learnt a lot. At the same time, my research reaches a new phase – lead the identification of novel etiologies of genetic cholestasis and explore the gene treatment for liver diseases.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Dr Chung Mo CHOW

Dr CHOW Chung Mo is a private paediatrician, who also works as a part-time Associate Consultant at Prince of Wales Hospital and Hong Kong Children Hospital, for providing paediatric gastroenterology services. He received his undergraduate training from the Chinese University of Hong Kong (CUHK) and obtained his paediatric fellowship in 2006. He also obtained the H. M. Lui Memorial Fund Fellowship in 2008 with oversea training in hepatology at Paediatric Liver Centre, King's College Hospital, London. Afterwards, he had actively participated in the Hong Kong Society of Paediataric Gastroenterology, Hepatology and Nutrition (HKSPGHAN). From 2015 to 2019, he was the President of HKSPGHAN. Currently, he still serves HKSPGHAN as an Immediate Past President. As an Honorary Clinical Associate Professor of CUHK, Dr CHOW also participated in research actively and published nearly 40 peer-reviewed articles in prestigious journals.

ABSTRACT

Paediatric Gastrointestinal Endoscopy: Hong Kong Experience

In Hong Kong, paediatric gastrointestinal endoscopy service has been established since 1970s. Learning from the experience in Hong Kong, common indications of oesphago-gastro-duodenoscopy (OGD) are epigastric pain, gastrointestinal bleeding, vomiting, foreign body, dysphagia and anemia. Neurological impaired children have higher diagnostic yield of OGD as compared to neurological normal children. They are more common to have esophagitis and gastric ulcers. Present of red flag signs (history of gastrointestinal bleeding, dysphagia, persistent vomiting, persistent right upper quadrant pain, nocturnal pain, family history of peptic ulcers disease and involuntary weight loss) help to identify the high-risk group of patients for detecting organic pathology by OGD. In children, helicobacter pyloric infection is the most common cause of gastrointestinal bleeding, which happens more common in older children and boys. Overall failure of eradication with first-line 1 week triple therapy has increased to 29.3% from 10% recently. Non helicobacter peptic ulcers have higher risk of recurrence, as compared to helicobacter peptic ulcer disease. For paediatric colonoscopy, rectal bleeding is the most common indication. However, inflammatory bowel disease has increased dramatically as the indication for colonoscopy in recent study. Experiences of endoscopic retrograde cholangiopancreatography (ERCP) and double balloon endoscopy in paediatric patients have been published and would be discussed in the lecture. New and advanced endoscopy procedures such as endoscopic ultrasound and submucosal dissection will be discussed. Paediatric patients will be benefit from the past experiences in Hong Kong, and also the development of new and advanced endoscopic techniques.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Dr Sharon Tsui Hang FUNG

Dr Fung is currently Associate Consultant (will be Consultant with effective date 1 Dec 2021) in Department of Paediatrics, Kwong Wah Hospital.

She is currently the general and neurology team head in Paediatrics/Kwong Wah Hospital. After graduated from the University of Hong Kong with a Bachelor of Medicine and Bachelor of Surgery, Dr Fung joined Paediatrics/Kwong Wah Hospital in 2002 and became fellow of the Hong Kong College of Paediatricians and the Hong Kong Academy of Medicine in 2009. In 2014, she was accredited as first fellow in the subspecialist in Paediatric Neurology of the Hong Kong College of Paediatricians. Dr Fung underwent oversea training for 6 months in the Department of Neurology, Great Ormond Street Hospital, London, United Kingdom in 2013 under the HM Lui Fellowship (Hong Kong College of Paediatricians) Award and another 3 months training in the Department of Neurology, Royal Children's Hospital, Melbourne, Australia under the HA Corporate Scholarship Program (Neuromuscular & Electromyography Fellowship Training).

ABSTRACT

Recent Advances in the Treatment of Paediatric Neuromuscular Disorders

Conventionally the management of paediatric neuromuscular disorders has been mainly supportive. In the last few years, with the advances in molecular genetics and accelerated novel therapeutic development, several new drug treatments have come into clinical use which turn some of conditions into "treatable" ones. Accompanying the ongoing research and rapid evolution of gene therapy, a number of promising strategies are developing and future new therapeutics may be life-saving or even "curative". Since 2017, Food and Drug Administration (FDA) have approved 3 new drugs for clinical use in Spinal Muscular Atrophy (SMA) patients. Both Nusinersen, an intrathecally administered antisense-oligoneucleotide (ASO) and Risdiplam, orally taken small molecules as splicing modifiers target at inclusion of exon 7 of SMN2 gene and transcription of more full length SMN2 protein. They are demonstrated to improve motor functioning, motor milestones and decrease tracheostomy and permanent ventilation in treated patients. Onasemnogene abeparvovec-xioi, AAV vector carrying SMN1 complimentary recombinant DNA, given as single intravenous injections in young patients, is shown to significantly improve the chance to reach developmental milestones. Over the past years, new drugs are also available for use in Duchenne Muscular Dystrophy (DMD) patients. Eteplirsen (exon 51 skipping) and Golodirsen (exon 53 skipping), both aim to restore reading frame and so production of internally truncated but functional dystrophin protein, have received conditional FDA approval to be used in DMD patients amendable to exon skipping. Ataluren, small molecules which selectively induce ribosomal read-through of premature stop condon and generation of relatively functional dystrophin protein is licensed in European Economic Area for patients older than 2 years with nonsense DMD mutations. A number of clinical trials using other exon skipping agents and AAV-mediated mini-/microdystrophin transfer are undergoing and more new therapeutic agents may come to clinical use soon.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Dr Dennis Tak Loi KU
Associate Consultant
Department of Paediatrics and Adolescent Medicine, Hong Kong Children's Hospital

- Interest in Paediatric Haematology and Oncology diseases
- Paediatric Neuro-Oncology Fellowship in The Hospital of Sick Children in Toronto, Canada (2014-2015)
- Team head, Solid Tumor & Neuro-Oncology Team in Hong Kong Children's Hospital
- D. H. Chen Foundation Clinical Research Fellowship (2021-2023)
- Clinical and research interest in novel therapies and personalized cancer medicine
- Past Chairman, Hong Kong Paediatric Haematology & Oncology Study Group (HKPHOSG)
- Member, SIOP-Europe Brain Tumour Group (SIOPE-BTG)
- Memeber, Society of Neuro-Oncology (SNO)
- Medical Advisor, Little Life Warrior Society (LLWS) for childhood cancer survivors and family

ABSTRACT

Neuro-oncology Training in SickKids: a Box of Unexpected Chocolates

I am very grateful with the support of HM Lui Memorial Fund scholarship, I pursued neuro-oncology fellowship training in Hospital of Sick Children (SickKids) in Toronto in 2014. The training experience was wonderful and full of surprises. Not only it helped me to build solid clinical knowledge for childhood brain tumours, but also broadened my linkage with world-wide experts and passionate peer oncologists. This fellowship program also provided valuable opportunities for research and academic collaboration.

"Life is like a box of chocolate." I could not imagine that this precious journey is still having continuous influence for my current clinical, academic and research development. In the coming HM Lui Memorial Fund 20th Anniversary Symposium, hope I could share my little "box of chocolate" with you.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Dr Lilian Po Yee LEE

Post:

- Associate Consultant, Department of Paediatrics & Adolescent Medicine, United Christian Hospital (since 2012)
- Specialist in Paediatric Respiratory Medicine, United Christian Hospital (since 2016)
- Paediatrician advisor, Children with Medical Complexity Community Support Programme (CCSP) of Kowloon East Cluster (since 2014)

Overseas training:

- 2011 Paediatric Intensive Care Unit, BC Children's Hospital, Vancouver, Canada
- 2017 Community and Societal Paediatrics, Wolfson Children's Hospital, Jacksonville, University of Florida, USA

Special interest:

- Home care and holistic management for children with medical complexity
- Education on counselling and discussion of Advance Care Plan

ABSTRACT

Medically Complex Children Care - A Coordinated Model from Hospital to Community

Thanks to the HM Lui Memorial Fund supported my 3-month sabbatical to the Division of Community & Societal Paediatric of Wolfson's Children Hospital in Jacksonville, Florida in 2017. I went to Jacksonville as a group of three, with two paediatric nurses, to learn the operation of community care of medically complex children. We took reference from the home care model of Community PedsCare® and grasped the idea of Bower Lyman Centre for Medically Complex Children. Focus is not on cure, but on care coordination in the medical system and individual case management.

Community care of medically complex children is an entirely different concept in our current Hong Kong practice which deals with all sorts of acute, chronic, financial, psychosocial and rehabilitation issues in acute hospital setting. This sabbatical enlightened us on navigating and networking with passionate working partners both inside and outside the hospital. It marked the formation of a brand new inter-disciplinary team in the Paediatric Department of United Christian Hospital. The team pioneers active handover and discharge plan, creates a unique follow-up platform and streamlines community services for complex children of the Kowloon East cluster. We name our new services the "BRight Project". Our works have earned affirmation and appreciation from parents and children of the district.

Coming back from Jacksonville, we have become advocates of the Children's Rights. We base our every decision on the sick children's best interest. We culminate a new culture of sublimating services from task-oriented approach to holistic people-oriented direction. Over the years, we delivered educational talks on Children's Rights to other fellow paediatricians, paediatric nurses, student nurses and teachers of special education needs (SEN) children. We are confident to take up the challenges ahead to practise and to preach what we experienced in Jacksonville.

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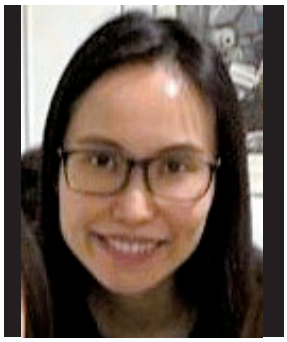

Dr Chantel Tsz Ying NG

Hello everyone, I'm Chantel Ng. I've undergone my Paediatric training at the New Territories Eastern Cluster and became a fellow in 2016. The road of training was a bit tortuous for me and at the time I had to choose a subspecialty training, all the conventional subspecialties already had enough trainees. After much thought and head raking, I decided to resort to my original passion of dermatology. I was very fortunate to be able to begin my training with Dr David Luk and Professor Hon, two of the most important persons and teachers of Paediatric Dermatology in Hong Kong, thereafter I received the HM Lui Fellowship award in 2017 and was able to go to one of the most prestigious centres for dermatology training in the world, the St. John's Institute of Dermatology in London for my elective training.

Paediatric dermatology is in most parts of the world, considered part of Dermatology, but in Hong Kong, due to many historical and practical reasons, children with skin problems are often presented to a Paediatrician. Although "paediatric dermatology" per se, may never be recognized as a paediatric subspeciality, I do believe, the knowledge behind this field is vast and genuinely requires in-depth training before one can confidently diagnose and treat children with skin problems or more extensive syndromes that present with dermatological cues.

ABSTRACT

Eczema and The Microbiome

Eczema is a widely common chronic inflammatory skin disease around the world, the etiology is multifactorial involving genetics and environmental causes. Substantial data also show that patients with eczema have a decreased microbiological diversity in their skin and gut and a disturbed microbial composition. Interaction between commensals and the immune system is believed to affect the maturation of the adaptive and innate immunity during early life, these seem to contribute to the onset of eczema and the progression along the atopic march.

Skin microbiome functions to protect the skin against pathogens and colonization, repairs the skin barrier and module immune responses. Bacterial colonization of the intestines and establishment of gut flora in infancy are closely linked with immune system development and findings from numerous studies suggest that aberrant gut microbiota precede the onset of atopic disease. Similar to skin commensals, differences in gut microbiota at species level are thought to be related to eczema. The gut microbiota is also closely linked to the skin flora.

The novel concept of modifying skin and gut microbiome by applying moisturizers that contain nonpathogenic biomass or selective modulation of the host flora by using pro-, pre-, or synbiotics during early years may be a preventive and therapeutic option in high risk groups and is currently a centre of interest. However, further research would be necessary to incorporate this knowledge to therapy.

HM LUI MEMORIAL FUND 20th ANNIVERSARY SYMPOSIUM

Dr Zita Gi Kay HUNG

Dr Hung currently holds the post of Associate Consultant at the Hong Kong Children's Hospital, Neonatal Intensive Care Unit with a team who is passionate about caring for babies in Hong Kong with complex medical and surgical needs. With a first degree in Systems Science Engineering, she returned to Hong Kong and graduated from the University of Hong Kong in 2007. She completed her pediatric training at the Princess Margaret Hospital and went to Edmonton, Canada in 2017 to complete a one-year clinical fellowship in Neonatal-Perinatal Medicine at The Stollery Children's Hospital. Apart from a clinical role at the Hong Kong Children's Hospital, Dr Hung also engages in teaching, clinical information system (CIS) development and data analytics. She has taught neonatal resuscitation (NRP) to learners in Canada and China. She is grateful and indebted towards countless role models and friends in her life who have demonstrated: dedication towards their work, kindness and compassion towards their patients, servant leadership towards their colleagues, and inspiring hard work beyond their call of duty.

ABSTRACT

Neonatal-Perinatal Medicine Training at The Stollery Children's Hospital (Edmonton, Canada)

It is my pleasure to share my one year experience at the Stollery Children's Hospital at the University of Alberta. I would like to thank the family of Mr HM Lui, and the trustees of the HM Lui Memorial Fund for their support.

During this year of hands-on PGME training at the Stollery Children's Hospital, I spent half my time at a level 3 surgical NICU, and the rest at a seventy-bed, level 2 and 3 NICU. My training and evaluation was identical to the programme for Canadian fellows. The fellowship program followed the CanMEDS framework, with competency in all the CanMED roles (Medical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, Professional) being supported and evaluated.

The structured and comprehensive program was invaluable in helping me become a better clinician and educator. I returned with a better understanding of the evidence behind many of our common practices such as hypothermia therapy for hypoxic-ischemic encephalopathy, or caffeine-use in preterm infants. There are large differences between the Canadian (public) healthcare system and Hong Kong's (private/public) healthcare system. My hope is that HK paediatricians will be able to advocate for smaller things that could still make a big difference. One such example is family-centered care. There is evidence that when you allow a family to be with their sick baby anytime, provide bedside support to the family, involve the parents as part of the clinical team and move towards shared decision-making, then parents will trust you more, the sick baby does better, and a healthier relationship forms between the family and team. My wish is that neonatal care in Hong Kong will be able to move towards such a model so that both the family and medical team will be able to partner to provide the best care to our babies and families.

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