DPP 2026

DIABETES PREVENTING THE PREVENTABLE FORUM 2026

17 May 2026 · Hong Kong

Organizer:

亞洲糖尿病基金會
Asia Diabetes Foundation

Co-organizers:

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

APCDS
Asia Primary Care Diabetes Society

DIABETOLOGISTS & ENDOCRINOLOGISTS ALLIANCE

Supporting organizations:

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

香港中文大學
The Chinese University of Hong Kong

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

香港醫學會
The Hong Kong Medical Association

香港女醫生協會
Hong Kong Women Doctors Association

香港內科學會
THE SOCIETY OF PHYSICIANS OF HONG KONG
FOUNDED 1956

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WELCOME MESSAGE

Dear faculty and delegates,

Every person with diabetes has a unique set of risk factors which the care team has to systematically measure, manage and monitor in order to prevent premature death and disabilities for preserving the quality of life.

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

The DPP Forum is an annual meeting which aims to foster collaborations amongst relevant stakeholders to develop care models which can bring out the best of our expertise and technologies in order to make chronic care accessible, sustainable and affordable.

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

We hope you will enjoy this meeting and that you will continue to be part of this growing network in pursuit of prevention and control of diabetes and chronic disease.

Professor Juliana Chan
Chairman

Professor Alice Kong
Co-chairman

Professor Andrea Luk
Co-chairman

ORGANIZER

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	Ms Amy Fu	Mr Jason Lam	Ms Renee Tse

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Members:	Prof Juliana Chan	Prof Alice Kong	Dr Tony O
	Dr Elaine Cheung	Dr Maria Leung	Dr Risa Ozaki
	Dr Edith Chow	Ms Kit Man Loo	Dr Rose Ting
	Prof Elaine Chow	Prof Andrea Luk	Dr Man Wo Tsang
	Dr Harriet Chung	Prof Ronald Ma	Prof Martin Wong

FACULTY MEMBERS

Elaine Yee Kwan Chow

Clinical Associate Professor, Department of Medicine & Therapeutics and Deputy Medical Director (non-oncology), Phase 1 Clinical Trial Centre, The Chinese University of Hong Kong

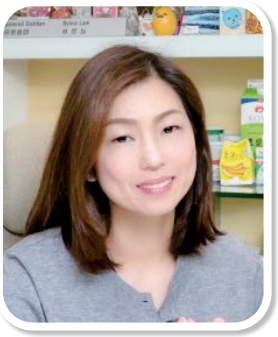
Prof Elaine Yee Kwan Chow is the Clinical Associate Professor, Department of Medicine & Therapeutics and Deputy Medical Director (non-oncology), Phase 1 Clinical Trial Centre, The Chinese University of Hong Kong. She received her medical training in UK and completed her PhD on cardiovascular effects of hypoglycaemia in type 2 diabetes. She joined the Chinese University of Hong Kong in 2015, where she helped set up glucose clamp and sensor evaluation studies at the Phase 1 Clinical Trial Centre. She secured a number of external grants, and currently leads clinical trials on use of CGM in prediabetes, advanced chronic kidney disease and peritoneal dialysis. In particular, she is interested evaluation of insulins, GLP1-ra, as well as other drug and non-drug interventions for cardio-reno-metabolic disorders. She has been principal investigator or co-investigator for over 100 Phase 1 to 4 studies relating to cardiometabolic drugs. She has published over 100 peer-reviewed articles, including articles in *Diabetes Care*, *Diabetes* and *Nature Reviews Endocrinology*. She has also received several awards, including the Hong Kong College of Physicians Sir David Todd Lecture in 2024, The HKCP Richard Yu Lecture and Women's Interprofessional Network of the American Diabetes Association abstract award in 2022. In addition to teaching and research, she is associate editor for *Diabetes Research Clinical Practice* and editorial board member for several journals.

Alice Pik Shan Kong

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

Prof Alice Pik Shan Kong is Professor, Division of Endocrinology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong. Her research interests are diabetes and obesity with focuses on clinical trials related to novel technology and therapeutic strategies, and emerging complications. She is the Editor in Chief of Primary Care Diabetes, Editorial Board Member of Diabetes Care, Section Editor of Current Diabetes Reports, and International Associate Editor of Diabetes Technology and Therapeutics. Prof Kong is dedicated to teaching and won the Faculty Education Award in 2022. She has presented at numerous meetings and has published over 400 articles in peer-reviewed international journals.

FACULTY MEMBERS



Sylvia See Way Lam

Senior Registered Dietitian and Vice Chairperson & former Chairperson, Hong Kong Academy of Accredited Dietitians

Ms Sylvia See Way Lam is a Senior Registered Dietitian with over 20 years of clinical experience in Hong Kong, specializing in obesity, diabetes, cardiometabolic health, and eating disorders. She has held major leadership roles, including Vice Chairperson and former Chairperson of the Hong Kong Academy of Accredited Dietitians, and serves as Honorary Consultant to the Hong Kong Dietitians Association. A respected speaker, author of 15 nutrition books, and co-host of a weekly RTHK radio program, Ms Lam provides expert consultancy across hospitals, clinics, corporations, and sports teams. She is widely recognized for advancing public nutrition education and professional dietetic practice.

Eunice Ka Hong Leung

Associate Consultant, Endocrinology Division, Department of Medicine, Queen Mary Hospital

Dr Eunice Ka Hong Leung is an Associate Consultant, Endocrinology Division, Department of Medicine, Queen Mary Hospital. She is also an Honorary Clinical Associate Professor, Department of Medicine, The University of Hong Kong. She obtained her medical degree from The University of Hong Kong and completed her medical and endocrinology training at Queen Mary Hospital, Hong Kong.

FACULTY MEMBERS

Kenneth Ka Hei Lo

Assistant Professor, Department of Food Science and Nutrition, Faculty of Science, The Hong Kong Polytechnic University

Prof Kenneth Ka Hei Lo is an Assistant Professor, Department of Food Science and Nutrition, Faculty of Science, The Hong Kong Polytechnic University, Vice President, Hong Kong Nutrition Association, and a registered public health nutritionist. His research examines the roles of dietary patterns for chronic disease prevention and management. He has a strong publication record with over 110 papers, receiving over 3,500 citations, and has been named a Stanford University World's Top 2% Most Cited Scientist since 2023.

Marques Shek Nam Ng

Assistant Professor, The Nethersole School of Nursing, Faculty of Medicine, The Chinese University of Hong Kong

Prof Marques Shek Nam Ng is an Assistant Professor, The Nethersole School of Nursing, Faculty of Medicine, The Chinese University of Hong Kong. He specialises in supportive care for kidney disease, with research on symptom clusters, psychological interventions, and health inequities. His recent work examines financial implications of kidney disease on patient outcomes and healthcare access. A former Fulbright Scholar at UCSF, he also serves as the Deputy Chair of the International Society of Nephrology Kidney Health Professionals Working Group.

FACULTY MEMBERS

Tony Chun Kwan O

Clinical Lecturer, Division of Clinical Pharmacology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong

Dr Tony Chun Kwan O is the Clinical Lecturer, Division of Clinical Pharmacology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong. He is an early career clinical researcher in Department of Medicine and Therapeutics, The Chinese University of Hong Kong. He has a particular interest in precision and structured care of individuals with diabetes, especially young-onset diabetes. He has been engaged in multiple epidemiological and interventional studies investigating the effects of incorporation of novel components such as biogenetic information and cognitive behavioural therapy on glycemic control and long-term outcomes in individuals with diabetes.

Guangming Tan

Clinical Assistant Professor, Division of Cardiology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong

Prof Guangming Tan is the Clinical Assistant Professor, Division of Cardiology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong. He obtained his medical degree at the Chinese University of Hong Kong. He completed his physician and cardiology specialist training at the Prince of Wales Hospital in Hong Kong. Prof Tan undertook his oversea fellowship in Vascular Medicine and Intervention at the Massachusetts General Hospital, Harvard Medical School, Boston from year 2017 -2018. He is a cardiologist with research interest in heart failure, coronary artery disease, cardiovascular risk factors management, peripheral vascular disease, pulmonary vascular disease, digital solution to cardiovascular disease, exercise therapy and endovascular intervention.

FACULTY MEMBERS

Brian Tomlinson

Professor, Faculty of Medicine, Macau University of Science and Technology

Prof Brian Tomlinson is Professor, Faculty of Medicine, Macau University of Science and Technology. He was previously Professor of Medicine and Therapeutics at The Chinese University of Hong Kong. He works with international groups on lipid and metabolic disorders and is currently Chair of the Asia-Pacific Federation of the International Atherosclerosis Society. He has published extensively in major journals including The New England Journal of Medicine and is an invited speaker at international meetings several times a year.

Yun Kwok Wing

Professor (Clinical) & Chairman, Chon-Ming Li Professor of Psychiatry, Department of Psychiatry, Faculty of Medicine, The Chinese University of Hong Kong

Prof Yun Kwok Wing is the Choh-Ming Li Professor of Psychiatry and Chairman, Department of Psychiatry, The Chinese University of Hong Kong. He is also the Director, Li Chiu Kong Family Sleep Assessment Unit, The Chinese University of Hong Kong.

Engaging in extensive interdisciplinary collaboration, Prof Wing has developed a focused line of novel scientific inquiry that centred on sleep and circadian medicine, with a recent emphasis on digital-AI medicine. By integrating diverse fields such as general medicine, clinical psychiatry, pediatrics, public health, neuropsychiatry, and digital-AI approach, Prof Wing aims to enhance the understanding of sleep-related and mental conditions and their impact on overall well-being across life span.

Prof Wing was awarded the distinguished national award for Sleep Medicine Scientific Technological Advance by the Chinese Medical Doctor Association and distinguished contributions to the development of sleep medicine and sleep research by Chinese Sleep Research Society.

FACULTY MEMBERS

Martin Chi Sang Wong

Professor, JC School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong

Prof Martin Chi Sang Wong is Professor, JC School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong. He specializes on chronic disease prevention. He has been the Co-Chairman of the Health and Medical Research Fund, the Health Bureau (HHB); Convener of the Advisory Group on Hong Kong Reference Framework for Care of Diabetes and Hypertension in Primary Care Settings. He has over 600 publications in peer-reviewed journals and ranked the top 0.07% in his research field by *expertscape*. He was selected as a highly cited researcher by Clarivate in 2024 and 2025.

Michele Mae Ann Yuen

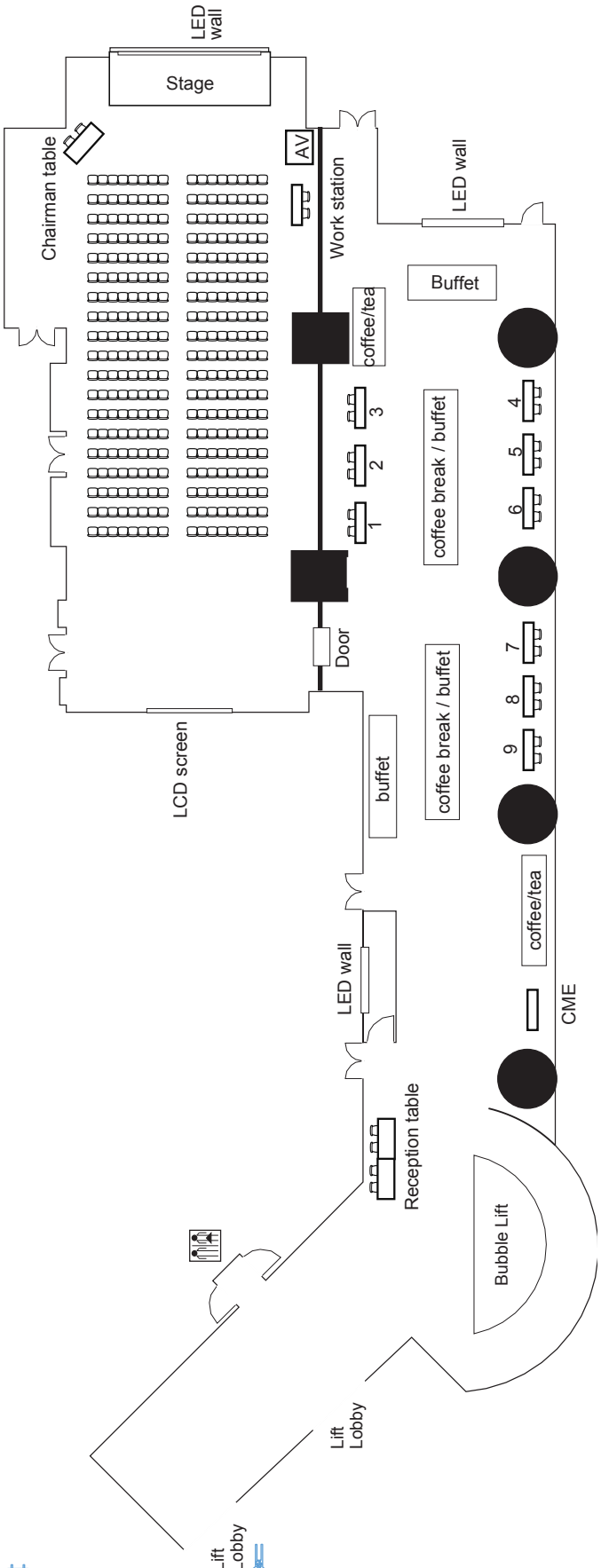
Specialist in Endocrinology, Diabetes & Metabolism and Honorary Clinical Assistant Professor, Department of Medicine, The University of Hong Kong

Dr Michele Mae Ann Yuen is a Specialist in Endocrinology, Diabetes and Metabolism. She is currently in private practice and is an honorary consultant at Gleneagles Hong Kong Hospital and Hong Kong Adventist Hospital. She is also an honorary associate consultant at Queen Mary Hospital and clinical assistant professor at the University of Hong Kong. She sub-specialized in Obesity Medicine at the Obesity, Metabolism and Nutrition Institute of the Massachusetts General Hospital / Harvard Medical School. Dr Yuen founded the Hong Kong Obesity Society in 2016 to support the development of Obesity Medicine in Hong Kong.

SCIENTIFIC PROGRAM

17 May 2026 (Sunday)		
08:45 - 09:10	Registration	
09:10 - 09:15	Welcome remarks	Juliana Chung Ngor Chan
Symposium 1 ***Co-chairs: Dr Risa Ozaki and Ms Theresa Yeung***		
09:15 – 09:45	Inverted food pyramid – from theory to practice	Sylvia See Way Lam
09:45 – 10:15	Controversies and consensus on time restricted eating	Kenneth Ka Hei Lo
10:15 – 10:45	Impact of CGM on engaging people with diabesity for lifestyle changes	Alice Pik Shan Kong
10:45 – 11:00	Break	
Symposium 2 ***Co-chairs: Dr Elaine Cheung and Dr Maria Leung***		
11:00 – 11:30	Staging of prediabetes: implication on prevention and treatment	Tony Chun Kwan O
11:30 – 12:00	Local consensus on redefining obesity	Michele Mae Ann Yuen
12:00 – 12:30	Lipid lowering drugs beyond statins	Brian Tomlinson
12:30 – 13:30	Lunch	
Symposium 3 ***Co-chairs: Dr Edith Chow and Dr Rose Ting***		
13:30 – 14:00	Evidence-based effects of GLP1 and GLP1-GIPRA on extra-vascular complications	Eunice Ka Hong Leung
14:00 – 14:30	Mental and sleep health, and diabesity	Yun Kwok Wing
14:30 – 15:00	Social and psychological determinants of chronic diseases	Marques Shek Nam Ng
15:00 – 15:15	Break	
Symposium 4 ***Co-chairs: Dr Harriet Chung and Dr Man Wo Tsang***		
15:15 – 15:45	Update on reference framework on diabetes care in Hong Kong	Martin Chi Sang Wong
15:45 – 16:15	Peripheral arterial disease (PAD) in diabetes: prevention of complications through early screening and diagnosis	Guangming Tan
16:15 – 16:45	CGM and artificial intelligence	Elaine Yee Kwan Chow
16:45 – 16:50	Closing remarks	Alice Pik Shan Kong

FLOOR PLAN AND EXHIBITORS



Booth No.	Exhibitors Name
1	Boehringer Ingelheim (Hong Kong) Limited
2	Celki International Limited
3	Merck Pharmaceutical (HK) Limited
4	Servier Hong Kong Limited
5	Abbott Laboratories Limited
6	Novo Nordisk Hong Kong Limited
7	AstraZeneca Hong Kong Limited
8	Daiichi Sankyo Hong Kong Limited
9	Sanofi Hong Kong Limited

ACADEMIC ACCREDITATIONS

College Name	CDE/CE/CEU/CME/CNE/CPD points
Association of Hong Kong Diabetes Nurses Limited (For ALL NURSES)	6
College of Pharmacy Practice	7.5
Hong Kong Academy of Accredited Dietitians	5
Hong Kong College of Community Medicine	6
Hong Kong College of Emergency Medicine	6
Hong Kong College of Paediatricians	6
Hong Kong College of Physicians	6
Hong Kong College of Radiologists	6
Hong Kong Dietitians Association	1 core + 4 non-core
Hong Kong Nutrition Association Limited	5
Hong Kong Podiatrists Association	3
International Podiatrists Association of Hong Kong	10
Medical Council of Hong Kong	5
Medical Laboratory Technologists Board	3.5
Occupational Therapists Board	Pending
Physiotherapists Board	Pending
The College of Ophthalmologists of Hong Kong	6
The College of Surgeons of Hong Kong	6
The Hong Kong College of Anaesthesiologists	6
The Hong Kong College of Family Physicians	5
The Hong Kong College of Obstetricians and Gynaecologists	5
The Hong Kong College of Orthopaedic Surgeons	5
The Hong Kong College of Otorhinolaryngologists	3.5
The Hong Kong College of Pathologists	6
The Hong Kong College of Psychiatrists	6

SYMPOSIUM 1

09:15 - 09:45

Inverted food pyramid – from theory to practice

Sylvia See Way Lam

Senior Registered Dietitian and Vice Chairperson & former Chairperson, Hong Kong Academy of Accredited Dietitians

The release of the 2025–2030 Dietary Guidelines for Americans (DGA) and its redesigned inverted food pyramid has generated significant debate among health professionals due to its visual emphasis on protein foods, full-fat dairy, and unprocessed fats, alongside the repositioning of whole grains at the narrow base. This presentation examines the scientific evidence behind the guidelines and clarifies misconceptions arising from the new illustration. Although the visual model appears to elevate red meat and saturated fats, major organisations—including the American Heart Association and World Cancer Research Fund—affirm that core recommendations remain unchanged: prioritising fruits, vegetables, whole grains, and minimally processed foods while limiting saturated fat, added sugars, and refined carbohydrates.

Key controversies addressed include the potential cardiometabolic and cancer risks associated with higher red-meat and saturated-fat intake, the misinterpretation that carbohydrates should be restricted broadly, and concerns about increased protein intake in relation to chronic kidney disease. Evidence continues to support plant-forward dietary patterns, fibre-rich whole grains, and moderation of red meat. Higher protein intake (1.2–1.6 g/kg/day) is justified for sarcopenia prevention, but plant proteins and seafood remain preferred sources for kidney and metabolic health.

The talk highlights the importance of contextualising dietary guidelines within cultural and local food environments. While the US pyramid serves as a communication tool, it should not be adopted wholesale by regions with distinct dietary patterns, such as Hong Kong. Effective public-health nutrition guidance must integrate Western scientific evidence with local food culture, affordability, and population needs.

Ultimately, healthcare practitioners play a critical role in interpreting the new DGA accurately, countering misinformation, and reinforcing evidence-based messages that emphasise plant-forward eating, whole grains, moderation of saturated fats, and culturally relevant dietary practices.

09:45 – 10:15

Controversies and consensus on time restricted eating

Kenneth Ka Hei Lo

Assistant Professor, Department of Food Science and Nutrition, Faculty of Science, The Hong Kong Polytechnic University

Time restricted eating (TRE), a form of intermittent fasting that confines daily intake to a defined window, has attracted increasing interest for its potential to improve obesity and cardiometabolic outcomes. However, significant controversy persists along two principal lines. The first concerns whether TRE's benefits are primarily mediated by reduced energy intake. Critics contend that a shorter eating window produces spontaneous caloric restriction and that metabolic improvements simply reflect lower total energy intake. Countering this, several randomized controlled trials report cardiometabolic improvements with TRE compared with calorie restricted controls, implying additional physiological mechanisms.

The second debate focuses on the timing of the eating window. Early TRE (window in the morning to late afternoon) more closely aligns with endogenous circadian rhythms, glucose tolerance and insulin sensitivity are generally higher in the morning, and multiple observational and interventional studies indicate greater improvements in glycaemic control and lipid profiles with early versus late windows. Conversely, late TRE (window in late morning/noon to the evening) tends to be more compatible with social and work schedules, and may therefore achieve better adherence in many adults, but it risks attenuated metabolic benefit due to evening melatonin secretion and reduced insulin sensitivity.

This seminar will summarize recent clinical and preclinical evidence comparing early and late TRE, evaluates guideline recommendations for TRE in diabetes management, and discusses plausible mechanisms through the lens of chrono nutrition, the study of how meal timing interacts with circadian biology to influence metabolic regulation. Practical implications for implementation and feasibility will also be addressed. Attendees will expect leave with an updated, evidence based understanding of TRE's potential benefits and limitations, which can help to communicate with their patients when handling relevant issues.

10:15 – 10:45

Impact of CGM on engaging people with diabesity for lifestyle changes

Alice Pik Shan Kong

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

Glucose monitoring is an important component of diabetes management. Continuous glucose monitoring (CGM) has been shown to reduce hypoglycemia, improve glycemic control, quality of life and psychological well-being in many people with diabetes. Through the provision of biological feedback in real-time, CGM has the potential to empower people with diabetes and obesity to make informed decisions for choices of food and exercise, engage them for behavioral modifications leading to the achievement of the goal of precision medicine. In this lecture, a review of the current literature for the use of CGM as a behavioral intervention tool in people with diabetes and obesity for lifestyle changes will be discussed.

SYMPOSIUM 2

11:00 – 11:30

Staging of prediabetes: implication on prevention and treatment

Tony Chun Kwan O

Clinical Lecturer, Division of Clinical Pharmacology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong

Identification of individuals with prediabetes for targeted intervention has been proposed and implemented to combat the huge burden of diabetes and associated complications. While intensive lifestyle intervention and multiple medications including metformin and alpha-glucosidase inhibitors have been proven useful, controversy remains regarding who and how to intervene due to limited evidence and resource consideration. The strong evidence supporting intensive lifestyle intervention and/or metformin to delay diabetes onset come from major trials mostly recruiting individuals with IGT, but not isolated IFG. Intervening all individuals with prediabetes would render the prevention program approaching a population scale due to its high prevalence especially if the more inclusive prediabetes criteria are used. Not all individuals with prediabetes are at substantially elevated risk of diabetes/ complications. Intervening individuals at the low-risk end would likely not offer much absolute risk reduction, hence not cost-effective.

Different groups of experts have proposed use of a staging or stratifying schema to increase the granularity of prediabetes risk profiling for guiding research and implementation programs. These include incorporation of OGTT-1hPG on top of conventional glycemic measures, and use of the number of elevated glycemic values to stratify risk. Importantly, extra-glycemic measures are also emphasized to recognize those at elevated risk but normoglycemia, and differentiate the rate of deterioration in individuals with prediabetes. Some take a more aggressive step forward and propose individuals with prediabetic hyperglycemia and concomitant diabetes-related complications should be treated as having diabetes. The staging system incorporating extra-glycemic measures would rely heavily on robust risk prediction engines for incident diabetes +/- incident and prevalent complications to make it practical, especially for the young population with lower absolute prevalence. Despite a lot of missing to define the optimal approach to individuals with prediabetes, a proper staging or stratifying system could be a reasonable way out to guide more selective intervention balancing cost and benefit, while awaiting more research evidence to come.

11:30 – 12:00

Local consensus on redefining obesity

Michele Mae Ann Yuen

Specialist in Endocrinology, Diabetes & Metabolism and Honorary Clinical Assistant Professor, Department of Medicine, The University of Hong Kong

For decades, clinical and public health approaches to obesity have relied almost exclusively on **Body Mass Index (BMI)** as the primary diagnostic tool. While BMI provides a convenient, non-invasive surrogate for population-level data, it is increasingly recognized as an insufficient metric for individual clinical assessment. Its fundamental limitation lies in its inability to distinguish between lean muscle mass and adipose tissue, nor can it account for variations in **adiposity distribution**—such as visceral versus subcutaneous fat—which are critical determinants of metabolic risk. Furthermore, BMI fails to capture the functional, psychological, and physiological severity of obesity, treating a complex, chronic relapsing disease as a static weight-to-height ratio.

As the global medical community shifts toward a complications-centric definition of obesity, local healthcare ecosystems face a pivotal turning point. Relying on outdated international thresholds may lead to the underdiagnosis of high-risk individuals, particularly in populations where significant metabolic dysregulation occurs at lower BMI levels. Conversely, it can lead to the over-medicalization of "metabolically healthy" individuals with high muscle density. To facilitate effective, personalized management, there is an urgent need to modernize our diagnostic architecture.

This talk will examine the critical discussions and evidence-based rationale behind the establishment of **localized BMI cut-offs**, acknowledging the unique phenotypic expressions of obesity within our specific population. We will delve into a proposed multi-dimensional framework designed to update local diagnostic criteria, moving beyond simple anthropometrics to integrate **metabolic health markers and functional assessments**.

By aligning local protocols with evolving international standards—such as those moving toward the incorporation of waist-to-height ratios and clinical staging systems—we can ensure that "obesity" is diagnosed not just by how much an individual weighs, but by how their weight impacts their health. Attendees will gain insights into the implementation of this framework, the necessity of interdisciplinary collaboration, and the ultimate goal of improving patient outcomes through a more nuanced, medically rigorous definition of the disease.

12:00 – 12:30

Lipid lowering drugs beyond statins

Brian Tomlinson

Professor, Faculty of Medicine, Macau University of Science and Technology

Statins are the first line treatment to reduce low-density lipoprotein (LDL) cholesterol and the risk of cardiovascular disease (CVD). If high dose statin is not sufficient to achieve LDL cholesterol targets the next drug to add is usually ezetimibe, which will provide an average additional reduction in LDL cholesterol of 20%. If this is still not sufficient to attain the LDL cholesterol goal the additional options include bempedoic acid and the proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors. Bempedoic acid can reduce LDL cholesterol by about 20% in addition to statin therapy or by about 25% when used as monotherapy. It provides an alternative for patients who are intolerant to statins and was shown to have cardiovascular benefits in this situation in the CLEAR Outcomes study. The monoclonal antibody inhibitors of PCSK9, alirocumab and evolocumab, have shown benefits in cardiovascular outcome studies in addition to statins and can reduce LDL cholesterol by an average of 60%. The small interfering RNA (siRNA) PCSK9 inhibitor inclisiran reduces LDL cholesterol by an average of 50% and can be given by injection every 6 months.

For patients with severe elevation of triglycerides, fibrates or omega-3 fatty acids should be used to lower triglycerides and reduce the risk of acute pancreatitis. Triglyceride-rich lipoproteins (TRLs) contribute to the risk for CVD and the formulation of eicosapentaenoic acid (EPA) as icosapent ethyl was shown to reduce the risk of CVD in patients with moderate hypertriglyceridaemia. Fibrates may be useful in certain patients with moderate hypertriglyceridaemia and it is important to ensure that all apolipoprotein B (ApoB) containing lipoproteins are reduced when using drug combinations to reduce the risk of CVD.

Angiopoietin-like protein 3 (ANGPTL3) and apolipoprotein C3 (apoC3) have been identified as new therapeutic targets primarily to reduce triglycerides but ANGPTL3 inhibitors were also found to be effective in reducing LDL cholesterol in patients with homozygous familial hypercholesterolaemia and the monoclonal antibody evinacumab has been approved for that indication. The apoC3 inhibitors olezarsen and plozasiran are effective in reducing triglycerides in severe hypertriglyceridaemia and have been approved for use in familial chylomicronaemia syndrome. Other drugs are in development to reduce lipoprotein(a) including an antisense oligonucleotide, siRNA drugs and an oral agent, and it should be possible to effectively reduce all atherogenic lipoproteins in the near future.

SYMPOSIUM 3

13:30 – 14:00

Evidence-based effects of GLP1 and GLP1-GIPRA on extra-vascular complications

Eunice Ka Hong Leung

Associate Consultant, Endocrinology Division, Department of Medicine, Queen Mary Hospital

Obesity represents a major and rapidly growing global health challenge. It is strongly associated with metabolic disorders, including type 2 diabetes mellitus (T2DM), dyslipidemia, hypertension, and cardiovascular disease. Beyond these well-recognized cardiometabolic sequelae, obesity contributes to a broad spectrum of extravascular complications, including metabolic dysfunction–associated steatotic liver disease (MASLD), obstructive sleep apnea (OSA), osteoarthritis (OA), and chronic kidney disease (CKD). These conditions significantly increase morbidity, impair quality of life, and impose a substantial healthcare burden, highlighting the need for treatments that address obesity-related multisystem disease.

Incretin-based therapies, particularly glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and dual GLP-1/glucose-dependent insulinotropic polypeptide receptor agonists (GLP-1/GIP RAs), have transformed obesity management. In addition to proven cardiometabolic benefits, these agents have also demonstrated improvements in a range of extravascular complications.

Semaglutide has demonstrated hepatic benefits in clinical trials. In the Phase 3 ESSENCE trial, 62.9% of patients achieved resolution of metabolic dysfunction–associated steatohepatitis (MASH) without worsening fibrosis, compared with 34.3% receiving placebo (estimated difference, 28.7%; 95% CI, 21.1 to 36.2; $P<0.001$). Additionally, a significantly greater proportion of patients experienced at least a one-stage fibrosis improvement without disease progression, supporting a disease-modifying effect in MASLD.

Tirzepatide has shown similarly promising liver outcomes. In the Phase 2 SYNERGY-NASH trial, MASH resolution without worsening fibrosis occurred in 10% with placebo, 44% with 5-mg tirzepatide (95% CI, 17 to 50), 56% with 10-mg tirzepatide (95% CI, 29 to 62), and 62% with 15-mg tirzepatide (95% CI, 37 to 69) ($P<0.001$ for all three comparisons).

Beyond hepatic disease, tirzepatide demonstrated substantial benefits in obesity-related OSA in the Phase 3 SURMOUNT-OSA program. Significant reductions in the apnea–hypopnea index were observed.

Musculoskeletal benefits have also been reported. In the STEP 9 trial, semaglutide 2.4 mg significantly improved pain, physical function, and mobility in patients with knee OA, alongside marked weight loss.

Renal protection represents another important extravascular benefit. Semaglutide is currently approved to reduce kidney disease progression and cardiovascular death in patients with T2DM and CKD, with emerging benefits also observed in individuals with obesity without diabetes. Ongoing trials will further clarify the renal effects of dual incretin therapy.

In conclusion, GLP-1 and GLP-1/GIP receptor agonists offer clinically meaningful, multisystem benefits extending beyond weight reduction, representing a paradigm shift in the treatment of obesity-related extravascular disease.

14:00 – 14:30

Mental and sleep health, and diabesity

Yun Kwok Wing

Professor (Clinical) & Chairman, Chon-Ming Li Professor of Psychiatry, Department of Psychiatry, Faculty of Medicine, The Chinese University of Hong Kong

Metabolism is closely regulated by sleep and circadian rhythms, and hormonal activity. Given this intimate relationship, sleep and circadian dysregulation has been shown to influence a variety of metabolic disturbances, particularly obesity and diabetes.

Sleep duration itself exhibits strong associations with obesity and diabetes. Extensive research has demonstrated that sleep duration modulates body weight across age groups. Robust evidence supports the link between short sleep duration and obesity, from childhood through older adulthood. In school-aged children, compensating for sleep loss during weekends or holidays has been found to mitigate the risk of overweight and obesity. Meanwhile, both short sleep and insomnia have been linked to an elevated risk of diabetes. Among sleep disorders, sleep-disordered breathing (SDB) is one of the best-known conditions linked to both obesity and diabetes. Furthermore, diabetes and glucose intolerance have been associated with SDB, and treatment of SDB may, in turn, influence glucose metabolism. Notably, the interactions among SDB, obesity, and diabetes have also been observed in pediatric populations.

On the other hand, there is close reciprocal relationship between sleep/circadian and mental health at which sleep intervention could ameliorate mental health problems. Thus, there will be a complex relationship among sleep/circadian, mental health and diabesity. Given these consistent findings, sleep emerges as a potentially modifiable factor in the prevention and management of obesity and diabetes.

With the continuing global epidemics of obesity, diabetes, depression and insufficient sleep, understanding the role of sleep, circadian and mental perspectives in metabolic health has become increasingly critical. This presentation will explore in detail the interrelationships among various sleep, circadian, depression and metabolic disorders, emphasizing the implications of healthy sleep and mental health practices for metabolic regulation and disease management.

14:30 – 15:00

Social and psychological determinants of chronic diseases

Marques Shek Nam Ng

Assistant Professor, The Nethersole School of Nursing, Faculty of Medicine, The Chinese University of Hong Kong

Global efforts to address chronic diseases increasingly recognise that health outcomes are shaped not only by biological factors, but also by the broader environments in which people live. The United Nations Sustainable Development Goals (SDGs) provide a comprehensive framework that situates health and wellbeing (SDG 3) within a network of interconnected goals, including poverty reduction (SDG 1), decent work and economic security (SDG 8), and reduced inequalities (SDG 10). This framework highlights health as both a contributor to and an outcome of sustainable development. Consistent with this perspective, the World Health Organization conceptualises health as being determined by a wide range of socioeconomic, behavioural, and environmental factors that shape exposures, vulnerabilities, and access to resources across the life course. Psychosocial determinants, such as mental wellbeing, financial status, and social support networks, play a critical role in influencing health-related behaviours, disease trajectories, and long-term outcomes, particularly for individuals living with chronic diseases.

In this presentation, Dr Ng highlights evidence from studies conducted in Hong Kong to demonstrate how psychosocial determinants shape health outcomes among individuals with chronic diseases. Findings indicate that poorer mental wellbeing is associated with higher healthcare utilisation and increased mortality risk, highlighting the impact of psychological health on health outcomes. Similarly, disadvantaged financial status reduces coping capacity, heightens psychosocial stress, and contributes to poorer health outcomes. In addition, barriers to accessing healthcare are linked to greater symptom burden, revealing gaps in the healthcare system itself as a determinant of health. These findings emphasise that addressing psychosocial determinants is essential for improving outcomes in chronic disease management. They point to key actions, including increasing awareness and routine assessment of psychosocial needs in clinical practice, developing and implementing targeted interventions to support mental wellbeing, financial resilience, and social support, and advocating for health equity through policies that improve access to care and address structural inequalities. Such actions are critical to aligning chronic disease management with the SDGs and fostering more equitable and sustainable environments for better health.

SYMPOSIUM 4

15:15 – 15:45

Update on reference framework on diabetes care in Hong Kong

Martin Chi Sang Wong

Professor, JC School of Public Health and Primary Care, Faculty of Medicine, The Chinese University of Hong Kong

Clinical guidelines like the RFs produced by the Primary Healthcare Commission (PHCC) provide physicians, caregivers, and patients on effective diagnosis, assessment, and management of diabetes based on up-to-date clinical evidence. They provide detailed algorithms and clinical recommendations on lifestyle modifications, therapeutic agents, targets for glycaemic, blood pressure, and lipid control, as well as complication screening and follow-up strategies.

However, guideline implementation and its actual adoption in clinical practice is challenging, requiring education, the use of decision support tools, coordination of patient care, and disease monitoring to ensure achievement of optimal targets. Organizational and system-level efforts are often necessary. Studies have found that when guidelines are effectively adopted in clinical workflows, they can satisfactorily improve clinical outcomes, attenuate clinical inertia, and result in better chronic disease control. Some benefits of using RF include reduced risk of complications, and lower hospitalization rates. On the other hand, patients may receive high-quality, standardized care. Furthermore, guidelines improve patient education, provide patient-friendly resources that can be adopted to educate patients about their diabetes condition and the significance of self-management. They assist healthcare organizations to identify knowledge gaps in diabetes management and implement quality improvement initiatives to enhance better outcomes.

The Expert Panel on Hong Kong Primary Healthcare Reference Framework has been regularly updating the guideline based on best evidence, international experiences, and local Advisory Group members of the RF. The first and the latest version was published on 2010 and 2023, respectively. The major key areas covered include Key areas covered include: (1). Screening, diagnosis, and classification of diabetes; (2). Lifestyle interventions and self-management education; (3). Medication management and therapeutic targets; (4). Prevention and monitoring of diabetes complications; and (5). Coordination of care with specialist services. This talk will summarise the revisions in the latest version to inform best practice for diabetes care in primary care settings.

Reference:
The Primary Healthcare Commission. Diabetes Care for Adults in Primary Care Settings. Available at: https://www.healthbureau.gov.hk/phcc/rfs/src/pdfviewer/web/pdf/diabetescare/en/16_en_RF_DM_full.pdf. Accessed on 21 March, 2026.

15:45 – 16:15

Peripheral arterial disease (PAD) in diabetes: prevention of complications through early screening and diagnosis

Guangming Tan

Clinical Assistant Professor, Division of Cardiology, Department of Medicine & Therapeutics, Faculty of Medicine, The Chinese University of Hong Kong

Peripheral artery disease (PAD) is a common but underrecognized complication in patients with diabetes mellitus. Its coexistence with diabetes markedly increases the risk of cardiovascular events and limb events including limb ischemia and amputation. Yet diagnosis is often delayed due to atypical symptoms and limited awareness. Early screening and timely diagnosis are therefore essential to prevent irreversible complications and improve outcomes.

In this presentation, we aim to review the burden of PAD in diabetes, highlighting the pathophysiological interplay of hyperglycemia, endothelial dysfunction, and accelerated atherosclerosis. Diabetic patients with PAD face higher rates of adverse cardiovascular and limb events compared to non-diabetic counterparts, underscoring the importance of proactive screening. Traditional risk factors such as smoking, hypertension, and dyslipidemia further compound the vascular risk, while neuropathy and impaired wound healing exacerbate the likelihood of non-healing ulcers and critical limb ischemia.

Screening test, including ankle-brachial index (ABI), toe-brachial index, duplex ultrasonography, and emerging non-invasive imaging, though provide practical means of early identification, though implementation remains inconsistent. Self-conducted screening test such as the Active Pedal Plantar-flexion test has been found to be an effective alternative to ABI. Current guidelines recommend systematic screening in diabetic patients over 50 years of age or with additional cardiovascular risk factors. Early diagnosis enables initiation of evidence-based interventions, including lifestyle modification, pharmacotherapy, and revascularization when appropriate. Multidisciplinary care involving diabetologists, cardiologists, vascular specialists, and podiatrists is critical to optimize outcomes.

16:15 – 16:45

CGM and artificial intelligence

Elaine Yee Kwan Chow

Clinical Associate Professor, Department of Medicine & Therapeutics and Deputy Medical Director (non-oncology), Phase 1 Clinical Trial Centre, The Chinese University of Hong Kong

It is estimated that up to 12% of people of people have impaired glucose tolerance (IGT) and 9.2% have impaired fasting glucose (IFG) globally in 2024. Abnormalities in postprandial glucose precede changes in fasting glucose, and screening with fasting glucose or HbA1c misses a significant proportion of people with isolated IGT who are at highest risk of progression. Continuous glucose monitoring (CGM) measures glucose directly and captures dynamic changes glucose. CGM and other wearables may therefore be helpful in screening for prediabetes as an alternative or complementing traditional biomarkers. In this talk, we will discuss applications of CGM towards personalised dietary interventions, highlighting our recent work comparing different carbohydrate diets in combination with metformin in prediabetes. We will also discuss the strengths and limitations of AI-powered diabetes prevention programs and a glimpse into the future on implementing these programs at scale with human-in-the-loop.

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25% RRR in CV death or HHF for patients with HFrEF[3]
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21% RRR in CV death or HHF for patients with HFpEF[4]
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*In T2DM patients with eCVD.[1]

†Lowest eGFR cut-off for initiation is 20 mL/min/1.73 m² for JARDIANCE® 10 mg and 30 mL/min/1.73 m² for JARDIANCE® 25 mg (for additional glycaemic control only); 25 mL/min/1.73 m² for dapagliflozin 10 mg; 45 mL/min/1.73 m² for canagliflozin 100 mg and 60 mL/min/1.73 m² for canagliflozin 300 mg (for additional glycaemic control only).[5-7]

CI=confidence interval; CKD=chronic kidney disease; CKM=cardio-kidney-metabolic; CV=cardiovascular; eCVD=established cardiovascular disease; eGFR=estimated glomerular filtration rate; HFpEF=heart failure with preserved ejection fraction; HFrEF=heart failure with reduced ejection fraction; HHF=hospitalisation for heart failure; HR=hazard ratio; RRR=relative risk reduction; SGLT2i=sodium-glucose cotransporter 2 inhibitor; T2DM=type 2 diabetes mellitus.

References: 1. Zinman B, et al. N Engl J Med 2015;373:2117-2128. **2.** Packer M, et al. N Engl J Med 2020;383:1413-1424. **3.** Anker SD, et al. N Engl J Med 2021;385:1451-1461. **4.** Herrington WG, et al. N Engl J Med 2023;388:117-127. **5.** JARDIANCE® Hong Kong Prescribing Information. **6.** Canagliflozin Hong Kong Prescribing Information. https://www.mims.com/hongkong/drug/info/invokana?type=full. Accessed on 28 Oct 2025. **7.** Dapagliflozin Hong Kong Prescribing Information. https://www.mims.com/hongkong/drug/info/forxiga?type=full. Accessed on 28 Oct 2025.

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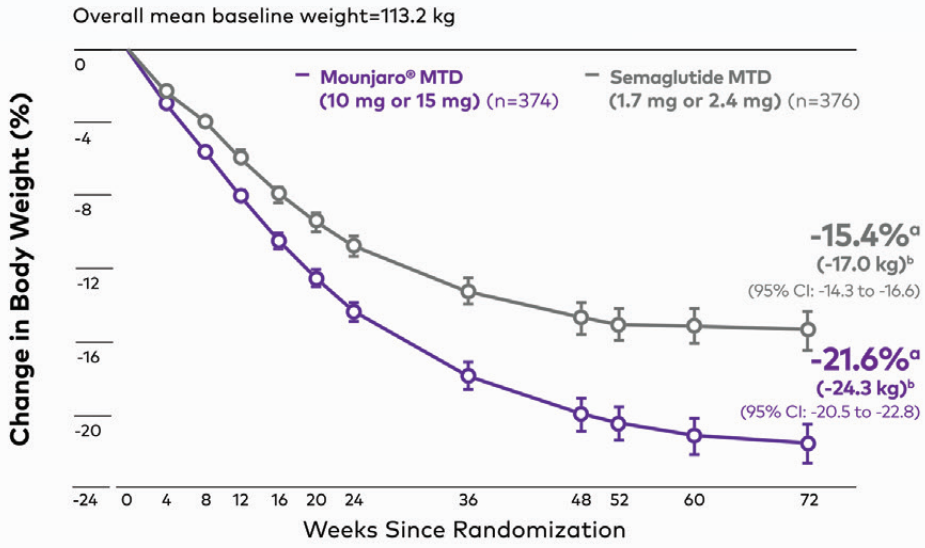
Significant weight loss: Up to 22.5% (-23.6 kg) average body weight reduction[1,3,*,†]

Cardiometabolic improvement: As demonstrated across key parameters, including blood pressure, waist circumference, triglycerides, HDL and LDL cholesterol[3,‡,§]

Mounjaro® vs semaglutide

40% greater relative reduction in body weight[4,‖]

Mean Percentage Change in Body Weight Over Time From Randomization to Week 72[4]



[a]I bars indicate 95% confidence intervals, adjusted for multiplicity.[4]
[b]Not adjusted for multiplicity.[4]

*In SURMOUNT-1 efficacy estimand, the weight loss of Mounjaro® was superior and clinically meaningful compared to placebo (p<0.001). The mean change at end of treatment (week 72) was -16.0% (a reduction of 16.1 kg) with Mounjaro® 5 mg dose; -21.4% (a reduction of 22.2 kg) with Mounjaro® 10 mg dose; -22.5% (a reduction of 23.6 kg) with Mounjaro® 15 mg dose and the mean change with placebo was -2.4% (a reduction of 2.4 kg), and included a reduced-calorie diet and increased physical activity.[1,3]

†Efficacy estimand, MMRM analysis, MITT population (efficacy analysis set).[1,3]

‡Mounjaro® is not indicated to reduce cardiometabolic parameters. In SURMOUNT-1 trial, reductions in blood pressure, waist circumference, triglycerides, HDL cholesterol and LDL cholesterol were secondary endpoints.[1,3]

§The efficacy estimand for individual doses was not adjusted for multiplicity, with the exception of waist circumference 10 mg and 15 mg.[3]

‖SURMOUNT-5 was a 72-week, phase 3b, multicenter, randomized, parallel-arm, open-label, comparator-controlled study that evaluated the efficacy and safety of Mounjaro® MTD (10 mg or 15 mg) compared with semaglutide MTD (1.7 mg or 2.4 mg) in adults with obesity (BMI ≥ 30 kg/m²) or overweight (BMI ≥ 27 kg/m²) with at least one weight-related complication, excluding diabetes. The study included a 2-week screening period. Mean baseline weight was 112.7 kg for Mounjaro® MTD (10 mg or 15 mg) and 113.4 kg for semaglutide MTD (1.7 mg or 2.4 mg). Participants in both the Mounjaro® and semaglutide treatment arms received lifestyle intervention, including a reduced-calorie diet and increased physical activity. Primary endpoint was mean percentage change in body weight from baseline to 72 weeks. Secondary endpoints were body weight reductions of 10%, 15%, 20%, and 25% from baseline to 72 weeks and change in waist circumference (cm) from baseline to 72 weeks. Primary and key secondary endpoints were adjusted for multiplicity. Limitation of an open-label study may be related to a bias in evaluation of the outcomes, efficacy, and/or safety, and analysis was not tested against a placebo-controlled comparison group.[5]

BMI = body mass index; GIP = glucose-dependent insulinotropic polypeptide; GLP-1 = glucagon-like peptide-1; HDL = high-density lipoprotein; LDL= low-density lipoprotein; mITT = modified intent-to-treat; MMRM = mixed model for repeated measures; MTD = maximum tolerated dose.

INDICATION[1]

Mounjaro® is indicated:

1. For the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise:
   - as monotherapy when metformin is considered inappropriate due to intolerance or contraindications
   - in addition to other medicinal products for the treatment of diabetes
2. For weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity in adults with an initial Body Mass Index (BMI) of ≥ 30 kg/m² (obesity) or ≥ 27 kg/m² to < 30 kg/m² (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, prediabetes, or type 2 diabetes mellitus).

SAFETY PROFILE[1,3,5-10]

Type 2 diabetes mellitus:
In 7 completed phase 3 studies, 5119 patients were exposed to Mounjaro® alone or in combination with other glucose lowering medicinal products. The most frequently reported adverse reactions were gastrointestinal disorders, including nausea (very common), diarrhea (very common), constipation (common), and vomiting (common). In general, these reactions were mostly mild or moderate in severity and occurred more often during dose escalation and decreased over time.

Weight management:
In 2 completed phase 3 studies, 2519 patients were exposed to Mounjaro® alone or in combination with other glucose lowering medicinal products. The most frequently reported adverse reactions were gastrointestinal disorders, including nausea (very common), diarrhea (very common), constipation (very common), and vomiting (very common). In general, these reactions were mostly mild or moderate in severity and occurred more often during dose escalation and decreased over time.

References: 1. Mounjaro® Hong Kong Prescribing Information. **2.** Willard FS, et al. JCI Insight. 2020;5(17):e140532. **3.** Jastreboff AM, et al. N Engl J Med. 2022;387(3):205-216. **4.** Aronne LJ, et al. N Engl J Med. 2025;393(1):26-36. **5.** Garvey WT, et al. Lancet. 2023;402(10402):613-626. **6.** Frias JP, et al. N Engl J Med. 2021 Aug 5;385(6):503-515. **7.** Rosenstock J, et al. Lancet. 2021 Jul 10;398(10295):143-155. **8.** Ludvik B, et al. Lancet. 2021 Aug 14;398(10300):583-598. **9.** Del Prato S, et al. Lancet. 2021 Nov 13;398(10313):1811-1824. **10.** Dahl D, et al. JAMA. 2022 Feb 8;327(6):534-545.

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

References: 1. LEQVIO, Hong Kong Prescribing Information. Novartis Pharmaceuticals Corp. 2021. **2.** RS Wright, FJ Raal, W Koenig, U Landmesser, LA Leiter, S Vikarunnessa, A Lesogor, P Maheux, Z Talloczy, X Zang, GG Schwartz, KK Ray, Inclisiran administration potently and durably lowers LDL-C over an extended-term follow-up: the ORION-8 trial, Cardiovascular Research, 2024;, cvae109, https://doi.org/10.1093/cvr/cvae109. **3.** Ray KK, Wright RS, Kallend D, et al; ORION-10 and ORION-11 Investigators. Two phase 3 trials of inclisiran in patients with elevated LDL cholesterol. N Engl J Med. 2020;382(16):1507-1519. doi:10.1056/NEJMoa1912387.

Leqvio® Important note: Before prescribing, consult full prescribing information. **Presentation: Solution for injection:** Each pre-filled syringe contains 1.5 mL of solution containing 284 mg inclisiran (equivalent to 300 mg inclisiran sodium). **Indications:** Leqvio is indicated in adults with primary hypercholesterolaemia (heterozygous familial and nonfamilial) or mixed dyslipidaemia, as an adjunct to diet: • in combination with a statin or statin with other lipid lowering therapies in patients unable to reach LDLC goals with the maximum tolerated dose of a statin, or • alone or in combination with other lipid lowering therapies in patients who are statin intolerant, or for whom a statin is contraindicated. **Dosage and administration:** Recommended dose: 284 mg inclisiran administered as a single subcutaneous injection: initially, again at 3 months, followed by every 6 months. Missed dose: • If a planned dose is missed by less than 3 months, inclisiran should be administered and dosing continued according to the patient's original schedule. • If a planned dose is missed by more than 3 months, a new dosing schedule should be started – inclisiran should be administered initially, again at 3 months, followed by every 6 months. Treatment Transition from PCSK9 Inhibitor Monoclonal Antibody: Inclisiran can be administered immediately after the last dose of a monoclonal antibody PCSK9 inhibitor. To maintain LDL C lowering it is recommended that inclisiran is administered within 2 weeks after the last dose of a monoclonal antibody PCSK9 inhibitor. **Special populations:** Renal impairment: No dose adjustments are necessary for patients with mild, moderate or severe renal impairment or patients with end stage renal disease. There is limited experience with inclisiran in patients with severe renal impairment. Inclisiran should be used with caution in these patients. **Hepatic impairment:** No dose adjustments are necessary for patients with mild (Child Pugh class A) or moderate (Child Pugh class B) hepatic impairment. No data are available in patients with severe hepatic impairment (Child Pugh class C). Inclisiran should be used with caution in patients with severe hepatic impairment. Pediatric patients (below 18 years): The safety and efficacy of inclisiran have not been established. Geriatric patients (65 years of age or above): No dose adjustment is necessary. **Method of administration:** Intended for administration by a healthcare professional. For subcutaneous injection into the abdomen. alternative injection sites include the upper arm or thigh. Injections should not be given into areas of active skin disease or injury such as sunburns, skin rashes, inflammation or skin infections. Leqvio should be inspected visually for particulate matter prior to administration. Each pre-filled syringe is for single use only. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Haemodialysis: Considering that inclisiran is eliminated renally, haemodialysis should not be performed for at least 72 hours after inclisiran dosing. **Pregnancy, lactation, females and males of reproductive potential Pregnancy:** There are no or limited amount of data from the use of inclisiran in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. As a precautionary measure, it is preferable to avoid the use of inclisiran during pregnancy. **Lactation:** It is unknown whether inclisiran is excreted in human milk. Available pharmacodynamic/toxicological data in animals have shown excretion of inclisiran in milk. A risk to newborns/infants cannot be excluded. A decision must be made whether to discontinue breast feeding or to discontinue/abstain from inclisiran therapy, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. Infertility: No human data. No effects on animal fertility. **Adverse drug reactions:** Common (≥1 to <10%): Adverse events at the injection site (includes injection site reaction, injection site pain, injection site erythema, and injection site rash). **Interactions:** Not a substrate, inhibitor or inducer of CYP450 enzymes or common drug transporters. Not expected to have clinically significant interactions with other medications. Drug-drug interaction assessments demonstrated a lack of clinically meaningful interactions with either atorvastatin, rosuvastatin or other statins. **Packs:** Solution in pre-filled syringe: 1's **Legal classification:** P1S1S3 Last revision: Sep 2021 Ref: EU Dec 2020.

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[a]Study design (CompoSIT-R study)[1]: A multinational, randomised, double-blind, active-comparator controlled, parallel group, noninferiority study was conducted to compare the efficacy and safety of sitagliptin (n=307) with dapagliflozin (n=306) in adults ≥25 years of age with type 2 diabetes and mild renal impairment over 24 weeks. All patients had an eGFR ≥60 and <90 mL/min/1.73m^2 and HbA1c ≥7.0% and ≤9.5% at screening. All patients were on a stable dose of metformin (≥1500 mg/day) with or without a sulfonylurea throughout the study. Patients in the sitagliptin group received 100 mg once daily. Patients in the dapagliflozin group initiated dapagliflozin 5 mg once daily at randomisation and were up-titrated to dapagliflozin 10 mg once daily at week 4. Up-titration was delayed or patients were down-titrated to 5 mg if unable to tolerate the higher dose in the opinion of the investigator. The primary objectives of this study were: (i) after 24 weeks, to assess the effect of the addition of sitagliptin compared with the addition of dapagliflozin on HbA1c; and (ii) over 24 weeks, to assess the overall safety and tolerability of sitagliptin in comparison to that of dapagliflozin.

[b]Study design (CVOT – TECOS)[2]: The TECOS was a randomised, double-blind, placebo-controlled trial assessing the impact of sitagliptin on a primary composite outcome of CV death, nonfatal stroke, nonfatal myocardial infarction, or unstable angina hospitalisations in patients with T2DM and CVD. 14,671 participants from 38 countries were enrolled. Eligible participants were ≥50 years old with T2DM, established atherosclerotic CVD, and HbA1c values of 6.5–8.0% (48–64 mmol/mol) on stable dose mono- or dual-combination therapy with metformin, pioglitazone, or sulfonylurea, or insulin with or without metformin. They were randomised to either sitagliptin or placebo at doses appropriate for their eGFR (except for eGFR <30 mL/ min/1.73m^2).

Abbreviations: CV=cardiovascular; CVD=cardiovascular disease; eGFR=estimated glomerular filtration rate; FDA=U.S. Food and Drug Administration; HbA1c=glycated hemoglobin; T2DM=type 2 diabetes

References: **1.** Scott, R., et al. Diabetes Obes Metab. 2018; 20(12): 2876–84. **2.** Green, J.B., et al. N Engl J Med. 2015; 373(3): 232–42. **3.** JANUVIA® (Sitagliptin) tablets for oral use. Label. U.S. Food and Drug Administration. Available from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/021995Orig1s053lbl.pdf. [Accessed 6 Sep 2024] **4.** Hong Kong Product Circular (JANUVIA®, MSD). **5.** Arechavaleta R, et al. Diabetes Obes Metab 2011;13:160-168. **6.** Ferreira JCA, et al. Diabetes Care 2013;36:1067-1073. **7.** Barzilai N, et al. Curr Med Res Opin. 2011;27:1049-1058. **8.** Ferreira JCA, et al. Am J Kidney Dis 2013;61:579-587. **9.** Josse RG, et al. Diabetes Obes Metab 2017;19:78-86

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

MSD

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27/F Lee Garden Two, 28 Yun Ping Road, Causeway Bay, Hong Kong.
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HK-DIA-00248 Apr/2026

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HK-PM-MSD-JAN-ONA-HCP-000002-04-24-2028

捐助機構：

賽馬會精準防控早發性糖尿病計劃
Jockey Club Precision Prevention Programme on Young Onset Diabetes

香港賽馬會慈善信託基金
The Hong Kong Jockey Club Charities Trust

香港首個結合生物遺傳標記來識別患有早發性糖尿病高風險人士的計劃，旨在及早識別有早發性糖尿病遺傳風險的人士，以便及早採取行動預防或延緩患上糖尿病。

合資格人士

18-44歲

沒有糖尿病

有最少1個糖尿病風險因素

- 中央肥胖/超重
- 糖尿病家族史
- 吸煙史
- 曾有高血壓/高血糖/不正常血脂指數/心血管疾病/脂肪肝
- 女士曾有妊娠糖尿病/多囊卵巢綜合症/曾生育四公斤或以上嬰兒
- 每星期運動少於150分鐘

立即報名

https://forms.gle/x5Zaj5tDwDSv3aj39

計劃內容

根據風險水平提供為期兩年的個人化干預

糖尿病風險評估
透過生物遺傳風險-基因測試(驗唾液)、血糖測試(篤手指)、體重指標及血壓等作風險分層

家庭醫生跟進

自我監察設備資助

護士提供個人化諮詢和教育

電子健康訊息

定期血液及尿液測試

藥物資助

專題工作坊或講座

了解更多

jc-pppyod.adf.org.hk

主辦機構：

香港中文大學 The Chinese University of Hong Kong
CU Medicine Faculty of Medicine The Chinese University of Hong Kong
香港糖尿病及肥胖症研究所 HONG KONG INSTITUTE OF DIABETES AND OBESITY
亞洲糖尿病基金會 Asia Diabetes Foundation
聖雅各福群會 St. James' Settlement

Certificate Course in
Obesity and Weight Management
2027

Early-bird Registration Deadline:
5 December 2026

Through a multidisciplinary teaching approach and interactive case study discussions, health care professionals can have an overview from epidemiology to pathophysiology, and develop a solid understanding in managing obesity and its co-morbidities.

What can I learn from this course?

Symposia

Overview of epidemiology, pathophysiology, medical hazards and management of obesity emphasizing the application of knowledge relevant to multidisciplinary practice

9 JAN 2027 (SAT) Obesity - from epidemiology to pathophysiology
- Weight management - past, present and future
- Exercise in weight management
- Cognitive-behavioral therapy of obesity

16 JAN 2027 (SAT) Management of obesity - from theory to practice
- Obesity- from brain to gut to liver
- Popular diets for weight management - are these sound diets?
- Obesity and diabetes - remission and prevention

Interactive Workshops

Case studies, interactive discussions and multidisciplinary approach are used to demonstrate the principles of diagnostic evaluation and management of obesity and its co-morbidities

23 JAN 2027 (SAT) Managing obesity related co-morbidities
- Clinical assessment of obesity
- Gynecological complications of obesity
- Peri-operative management of patients undergoing metabolic surgery
- Psycho-behavioral treatment of binge eating disorder in people with obesity

30 JAN 2027 (SAT) Managing obesity - a multidisciplinary approach
- Role of metabolic surgery in obesity management
- The role of gut microbiome in obesity
- Cardiovascular complications of obesity
- Practical dietary strategies for weight management

13 FEB 2027(SAT) MCQ Examination
- MCQ Examination

How about the fee

	Early-bird Fee	Standard Fee
Whole Course	HK$4,760	HK$4,830

Course Director

Professor Andrea Luk
Professor, Department of Medicine and Therapeutics, CUHK

Course Co-directors

Professor Juliana Chan
Professor of Medicine and Therapeutics and
Director of Hong Kong Institute of Diabetes and Obesity, CUHK

Professor Alice Kong
Professor, Department of Medicine and Therapeutics, CUHK

Teaching Faculty

Professor Juliana Chan
Dr Elaine Cheung
Professor Stanley Hui
Professor Alice Kong
Dr Shirley Liu
Professor Andrea Luk
Dr Joyce Mak
Professor Phoenix Mo
Dr Mandy Sea
Dr Guangming Tan
Dr Eric Tse
Dr Simon Wong

Can I get CME points?

CME Accreditation from the Following Professional Organizations

Approved CME points of professional organizations will be updated on our programme website

Application and Enquiries
Enquiry Hotline: (852) 3505-1419
Email: cowm@cuhk.edu.hk
www.hkido.cuhk.edu.hk
HKIDO

香港中文大學
The Chinese University of Hong Kong

CU Medicine HONG KONG
香港中文大學醫學院
Faculty of Medicine
The Chinese University of Hong Kong

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

International Diabetes Federation
Centre of Excellence in Diabetes Care 2024-25

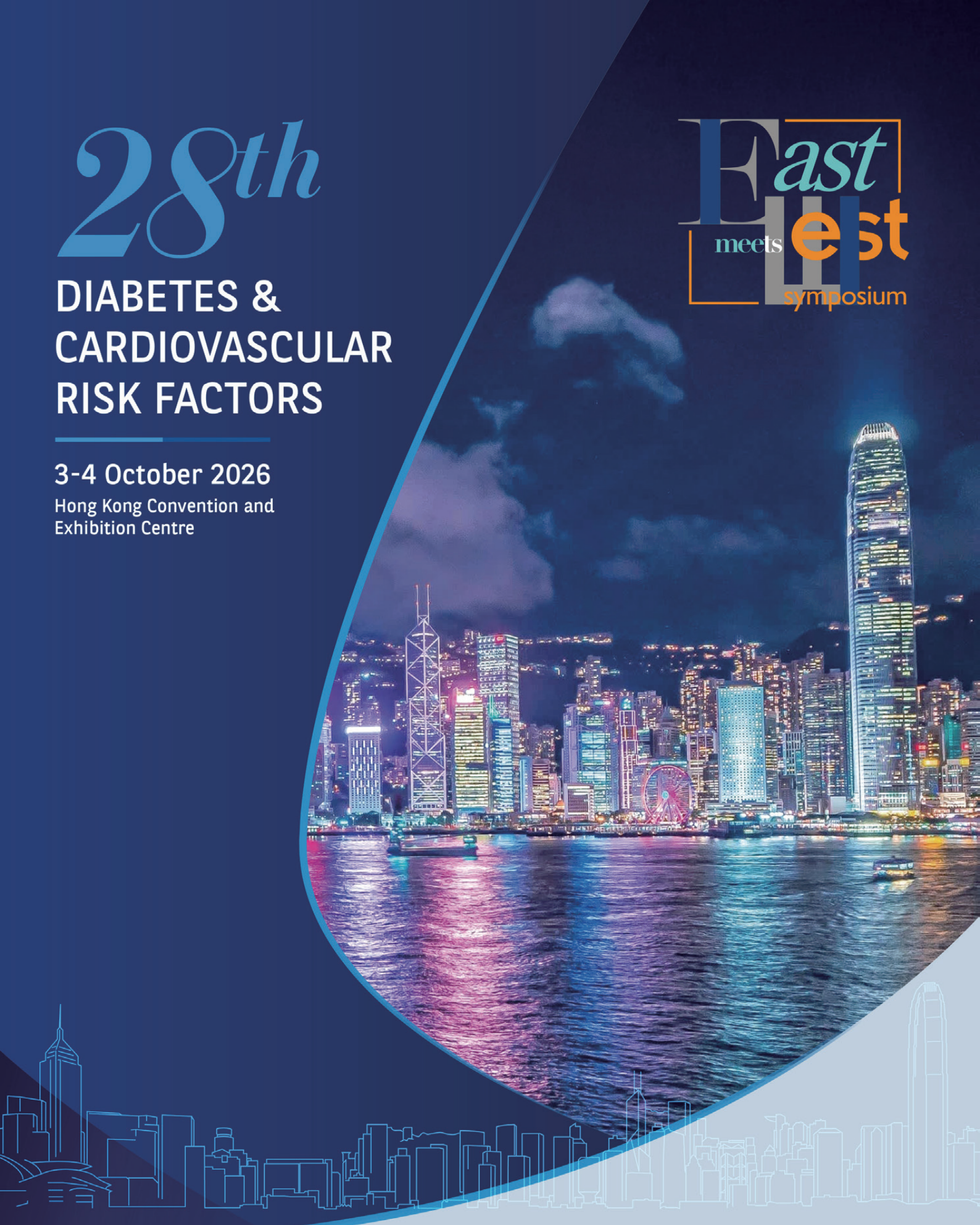
28th

DIABETES & CARDIOVASCULAR RISK FACTORS

East meets West symposium

3-4 October 2026

Hong Kong Convention and Exhibition Centre



Organizers

香港中文大學
The Chinese University of Hong Kong

CU Medicine
香港中文大學醫學院
Faculty of Medicine
The Chinese University of Hong Kong

香港糖尿病及肥胖症研究所
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2024-25

亞洲糖尿病基金會
Asia Diabetes Foundation

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