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HKCMA Membership Application



For Doctor



For Associate Member

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Introduction 導言



Dr. Christopher KM Hui
MBE FRCP
Specialist in Respiratory Medicine

許建名醫生

April Bulletin: Advances in Respiratory Medicine and Lung Health

Welcome to the April Bulletin, spotlighting breakthroughs in Respiratory Medicine. As a specialist, I'm excited to share how innovations are transforming patient care and addressing global health challenges like asthma and lung cancer, with a focus on their impact in China.

Why Advances in Respiratory Medicine Matter

Respiratory diseases, from COPD to lung cancer, are leading causes of death and disability worldwide. Cutting-edge developments in diagnostics, therapies, and technology are improving outcomes and reducing healthcare burdens, offering hope for millions with chronic and acute conditions.

Key Innovations

Biologics for Severe Asthma: A range of monoclonal antibodies and biologics treatments can reduce asthma exacerbations by up to 50%, providing relief for severe cases.

Lung Cancer Immunotherapy: Immunotherapy and target-therapy drugs boost survival rates for non-small cell lung cancer by 15-20%, even in advanced stages of the disease.

Advanced Bronchoscopy: Navigational bronchoscopy and endobronchial ultrasound enable earlier, less invasive lung lesion diagnosis.

AI in Imaging: AI tools enhance CT scan accuracy by 30%, aiding early detection of pulmonary issues.

Asthma and Lung Cancer: Global and Chinese Perspectives

Asthma and lung cancer pose significant challenges globally and in China, where environmental and lifestyle factors amplify their impact.

Asthma: Affecting 350 million globally, asthma impacts 45.7 million adults in China, driven by pollution and urbanization. It causes over 2 million hospitalizations yearly, highlighting the need for advanced treatments.

Lung Cancer: The top cancer killer worldwide, lung cancer claims 1.8 million lives annually. In China, over 800,000 new cases occur yearly due to smoking and air pollution, with a 19% five-year survival rate, underscoring the urgency for early detection and novel therapies.

Moving Forward

Respiratory medicine is at a turning point, with innovations driving better care. Addressing asthma and lung cancer, especially in high-burden areas of the country, requires collaboration among clinicians, researchers, and policymakers. This Bulletin explores some of these topics further, offering insights into improving respiratory health globally.

Join us for expert articles and research updates shaping the future of Respiratory and Critical Care Medicine!

Editor's Words 主編的話



Dr. Kacey KC Hau
Editor
HKCMA Bulletin

侯鈞翔醫生
香港中華醫學會會訊主編

世界在改變 疾病不會改變

2025 年開始了一百多天，整個世界都彷彿改變了。讀書的時候，我的老師教會我一個字，用來形容醫學這個專業：Apolitical——即使世局變換，社會或貧或富，都離不開疾病的痛苦。生老病死，從不會選擇某些「不幸」的人，而是我們每個人都「不幸」地必須經過的階段。按計劃，今期是以討論呼吸系統疾病為主題的醫療教育專輯，有許建名醫生下筆的關於哮喘的 CME 文章，也找來另一位專家、呼吸系統專科醫生王君玲分享肺功能的分析和解構。

青少年疾病也是前線醫生關注的話題。近年香港生育率下降，養育一名子女更顯珍貴，因此對於兒童及青少年的健康更值得重視及保持水平。對此，也有來自公營機構雅麗氏何妙齡那打素醫院兒童及青少年科顧問醫生、兒科內分泌專家黃偉進分享對孩子生長圖表的理解。皮膚科是一個圖像主導的專科（pictorial medicine），皮膚分享案例一向受到很多醫生同事歡迎。今次有資深皮膚科醫生、前衛生署皮膚科主管何景文的分享。醫學知識浩瀚而沉悶，我希望這種問答模式更能讓每位同仁把握重點，也帶起我們的初心，就如當日醫學生上導修課（tutorial）被詰問（「抽書」）的時光。計劃，還是趕不上變化。

因應香港醫療改革的新動向，邀請到好朋友現任香港立法會議員（醫療衛生界）、外科醫生林哲玄分享對剛出爐的“2025 年電子健康紀錄互通系統（修訂）條例草案”刊憲的看法。也有副會長、家庭醫學專科醫生朱偉星分析及回應醫院管理局（HA）提高收費對市民及業界的影響；也有腎科醫生、本身也是 IT 高手的何仲平學兄分享上傳病人資料的方法。寄望這個平台能成為業界互動和學習的好地方。

世界在改變，疾病不會改變。我們力求上進、保持本港醫療水平之餘，專業態度和操守也不應變。



Latest Updates in Asthma Management: A Focus on Biologics and Local Treatment Outcomes in Hong Kong



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Key words: Asthma; Severe asthma; Inhaled corticosteroids; Biologic therapy;

Abstract

Asthma is a chronic respiratory condition that affects millions of people worldwide. While conventional therapies such as inhaled corticosteroids (ICS) and bronchodilators remain the cornerstone of asthma treatment, advancements in biologic therapies have revolutionized management, particularly for patients with severe asthma. This review provides an update on the current state of asthma management, emphasizing biologics' role and efficacy. Additionally, it explores the local treatment landscape in Hong Kong, reviewing outcomes and efficacy data in the region.

Introduction

Asthma, characterized by chronic airway inflammation, reversible airway obstruction, and bronchial hyperreactivity, affects more than 300 million individuals globally. In Hong Kong, the prevalence of asthma is estimated to be 10.1% among children and approximately 5.6% among adults, representing a significant public health concern. Despite advances in treatment, uncontrolled asthma remains a challenge, with a subset of patients not responding to traditional

therapies, particularly those with severe asthma.

The emergence of biologics has provided an innovative approach to asthma management, targeting specific inflammatory pathways involved in the disease. This article reviews the latest updates in asthma management, with a specific focus on biologics and their local impact in Hong Kong.

Conventional Asthma Management

The Global Initiative for Asthma (GINA) guidelines remain the foundation for asthma management, promoting a stepwise approach to treatment. The use of inhaled corticosteroids (ICS) combined with long-acting beta-agonists (LABA) forms the basis of therapy for patients with persistent asthma. These treatments aim to control symptoms, reduce exacerbations, and improve overall lung function.

However, approximately 5-10% of asthma patients have severe or refractory disease that remains uncontrolled despite high-dose ICS/LABA therapy. This subgroup often experiences frequent exacerbations, reduced quality of life, and increased healthcare utilization. For these patients, novel therapies such as biologics offer new hope.

Biologics in Asthma Management

Overview of Biologics

Biologics are targeted therapies that act on specific components of the immune system to reduce inflammation and prevent exacerbations in patients with severe asthma. These treatments are particularly useful for patients with Type 2 inflammation, which is characterized by elevated

levels of eosinophils and other markers of allergic inflammation such as interleukin-4 (IL-4), interleukin-5 (IL-5), and immunoglobulin E (IgE).

There are currently several biologics approved for the treatment of severe asthma, including:

- **Omalizumab:** An anti-IgE monoclonal antibody that is particularly effective in patients with allergic asthma.
- **Mepolizumab, Benralizumab, and Reslizumab:** These biologics target IL-5 or its receptor, reducing eosinophil levels and preventing asthma exacerbations in patients with eosinophilic asthma.
- **Dupilumab:** A monoclonal antibody that blocks IL-4 and IL-13 signalling, effective in both eosinophilic and allergic asthma.
- **Tezepelumab:** A monoclonal antibody that targets thymic stromal lymphopoietin (TSLP), used to treat severe asthma by reducing exacerbations and improving lung function in both type 2 and non-type 2 asthma patients. It has shown efficacy in reducing asthma exacerbations across various asthma phenotypes.

These therapies represent a shift toward personalized medicine, where treatment is based on specific inflammatory profiles rather than a one-size-fits-all approach.

Latest Evidence for Biologics

1 Omalizumab (Xolair):

- Omalizumab has been shown to reduce asthma exacerbations by up to 38-43% and improve asthma control and quality of life in patients with moderate-to-severe allergic asthma (Chupp et al., 2017).
- A meta-analysis by Normansell et al. (2014) demonstrated that Omalizumab significantly reduces the number of exacerbations in both adults and children.

2. Mepolizumab (Nucala):

- Mepolizumab has proven efficacy in reducing eosinophilic inflammation, leading to a 50-60% reduction in asthma exacerbations (Pavord et al., 2012).

- The DREAM trial, a landmark study in severe eosinophilic asthma, confirmed that Mepolizumab decreases exacerbations and oral corticosteroid use (Bel et al., 2014).

3. Benralizumab (Fasenra):

- Benralizumab, another IL-5 receptor antagonist, has been shown to deplete blood eosinophils and lead to a 70% reduction in exacerbations in patients with severe asthma (FitzGerald et al., 2017).
- The SIROCCO and CALIMA trials support its role in improving lung function and reducing corticosteroid use (Bleecker et al., 2016).

4. Dupilumab (Dupixent):

- Dupilumab has emerged as a highly effective option for patients with both eosinophilic and allergic asthma. The QUEST trial demonstrated that Dupilumab reduces exacerbations by 47% and improves lung function (Castro et al., 2018).

5. Tezepelumab (Tezspire):

- TSLP therapies, like the monoclonal antibody tezepelumab, target the cytokine thymic stromal lymphopoietin to reduce inflammation and exacerbations in severe asthma. By blocking TSLP's interaction with its receptor, these treatments decrease airway hyper-responsiveness and improve lung function across a broad patient population. Approved by the FDA in 2021, tezepelumab is a key advancement in asthma management (Menzies-Gow et al., 2021).

Local Treatment Outcomes and Efficacy Data in Hong Kong

Asthma Prevalence and Control in Hong Kong

Asthma remains a prevalent condition in Hong Kong, affecting both adults and children. Studies conducted in the region highlight a considerable number of patients experiencing uncontrolled asthma, with frequent exacerbations leading to emergency department visits and hospitalizations.



According to data from the Hospital Authority of Hong Kong, asthma-related hospital admissions are common, particularly among the elderly and paediatric populations.

Efficacy of Biologics in Hong Kong

Biologics have gradually been incorporated into clinical practice in Hong Kong, particularly in tertiary centres such as the Prince of Wales Hospital and Queen Mary Hospital. Local data on biologics have echoed global findings, demonstrating improved outcomes for patients with severe asthma.

1. Omalizumab:

- Omalizumab has been in use in Hong Kong since its approval and has shown favourable results in reducing hospital admissions and improving quality of life. A study by Chan et al. (2018) at the Chinese University of Hong Kong found that patients treated with Omalizumab experienced fewer exacerbations and hospitalizations, in line with international studies.

2. Mepolizumab:

- Mepolizumab is available in select hospitals, and preliminary local data suggest it significantly reduces corticosteroid use and exacerbations in patients with eosinophilic asthma (Leung et al., 2019).

3. Benralizumab and Dupilumab:

- Benralizumab and Dupilumab are newer additions to the biologics available in Hong Kong, and local studies are ongoing to assess their long-term efficacy. Early results from hospital-based trials indicate that these biologics offer promising reductions in exacerbation rates, similar to global clinical trials.

4. Tezepelumab:

- Tezepelumab has shown benefits in reducing asthma exacerbations, particularly in patients with elevated IL-5 and IL-13 levels. It is administered subcutaneously,

typically every four weeks as a prescription-only medication, under Schedule 3.

The Role of Biologics in Personalized Medicine

The introduction of biologics marks a shift toward personalized asthma treatment. In Hong Kong, phenotyping patients based on biomarkers such as blood eosinophil levels and IgE is becoming more common. This approach allows clinicians to tailor therapy, selecting the most appropriate biologic based on a patient's underlying inflammatory profile.

The cost of biologic therapies remains a concern, and access is typically limited to patients with the most severe forms of asthma. However, ongoing studies on cost-effectiveness may lead to broader access in the future.

Conclusion

Asthma management has undergone significant advancements in recent years, with biologics offering new hope for patients with severe, uncontrolled asthma. These targeted therapies have demonstrated impressive reductions in exacerbations, improved lung function, and enhanced quality of life.

Biologics can help reduce dependency on corticosteroids in severe and uncontrolled asthma by targeting specific inflammatory pathways, thereby decreasing the need for both systemic and inhaled corticosteroids. This reduction in corticosteroid use can thus mitigate many of the acute and chronic side-effects associated with long-term corticosteroid therapy, improving overall patient outcomes and quality of life.

In Hong Kong, the use of biologics is expanding, with local data reflecting the global success of these treatments. As biologics become more widely available, Hong Kong's clinicians are increasingly adopting a personalized approach to asthma management, ensuring better outcomes for patients across the region.

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CME Questions

Please answer the following statements T (True) or F (False):

1. Biologic therapies are primarily indicated for patients with severe asthma who do not respond to conventional treatments.
2. In Hong Kong, the overall prevalence of asthma is higher in adults (5.6%) than in children (10.1%).
3. Inhaled corticosteroids (ICS) alone are considered the cornerstone of therapy for persistent asthma according to GINA guidelines.
4. Omalizumab is an anti-IgE monoclonal antibody effective in treating allergic-phenotype asthma.
5. Mepolizumab targets the IL-4 receptor to reduce eosinophilic inflammation.
6. Benralizumab has been shown to deplete blood eosinophils and reduce exacerbations by up to 70% in severe asthma.
7. Dupilumab blocks signaling for both IL-4 and IL-13, making it effective in eosinophilic and allergic asthma.
8. In Hong Kong, biologics like Omalizumab and Mepolizumab are exclusively available in primary care clinics.
9. Cost and limited access remain barriers to the widespread use of biologics in Hong Kong.
10. Personalized asthma management in Hong Kong involves phenotyping patients correctly based on biomarkers such as blood eosinophil levels and IgE.

Answer Sheet HKCMA Bulletin Issue 03 April 2025

Doctors are most welcome to answer the self-assessment questions to attain the CME point for respective authorities if 5 answers out of the 10 short questions are correct by returning the completed answer sheet via fax 3007 1019 or by email to info@hk-cma.org.hk on or before 10 June 2025 for documentation. Answers to questions will be provided in the next issue of the HKCMA Bulletin.

Latest Updates in Asthma Management: A Focus on Biologics and Local Treatment Outcomes in Hong Kong

By Dr. Christopher K.M. Hui, MBE FRCP, Specialist in Respiratory Medicine

Self-assessment Questions 1-10: Please answer T (true) or F (false)

1	2	3	4	5	6	7	8	9	10

Full Name (block letters): _____ Signature : _____

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Answers to Issue 02 January 2025

Role of immunotherapy in non-small cell lung cancer (NSCLC)

By Dr. Carol Kwok, Specialist in Clinical Oncology

1	2	3	4	5	6	7	8	9	10
False	True	False	False	True	False	False	False	True	False



Dermatology Case of a 28-year-old Lady



Contributor: Dr. King-man Ho

何景文醫生

Specialist in Dermatology & Venereology

A 28-year-old lady presented with these papular lesions at her neck and upper abdominal region. She first noted a few of these lesions at her teenage. These lesions have slowly increased in number over 10 years. Despite in a few occasions, a few of these papules were inflamed that resolved spontaneously, most are not symptomatic. On physical examination, these lesions were mostly skin color albeit some with very light red, or yellow or greyish hue. Lesions were mostly firm, non tender, and not fixing to underlying structure. She presented to dermatology clinic because she was told by a family physician that she might have got neurofibromatosis. What is the most likely diagnosis:



- A. Neurofibroma
- B. Acne cysts and scar
- C. Steatocystoma multiplex
- D. Epidermal cysts
- E. Leiomyoma

Steatocystoma multiplex is an inherited dermatological condition with hamartomatous malformations of the pilosebaceous duct junction. As in this lady, most cases first develop these skin lesions during their puberty. The mode of inheritance is mostly autosomal dominant, but can also be sporadic. Steatocystoma originates from the sebaceous duct and so regarded as the "true" sebaceous cyst whereas the commonly known "sebaceous cyst" is actually epidermoid cyst.

The chest and epigastric region are the sites of predilection, lesions may also occur over the abdomen, pubic region, upper limbs, face and in some cases all over the body.

The cysts are mostly ranging from 2 to less than 10 mm in size but they may be larger. Occasionally a small central greyish point is present and the cyst may contain one or more hairs and in that circumstance the pathology may be reported as vellus hair cyst.

As steatocystoma multiplex is a genetic disorder and so far there is no treatment to correct the underlying genetic abnormalities, treatment is limited to treat those inflamed or pustular lesions. Surgery or other ablative treatments will cause scarring and not prevent the occurrence of new lesions, and so may not meet the aesthetic result expected by an individual patient, therefore, before embarking on these procedures, the attending doctor have to consider seriously and deliberate with the involved patient.

Question answer: C

Paediatric Case of a 2-year-old Pakistani Girl



Contributor: Dr. Sammy WC Wong

黃偉進醫生

Specialist in Paediatric Endocrinology

A 2-year-old Pakistani girl, born full term in Hong Kong with a birth weight of 2.6 kg, presented to the clinic due to concerns about her short stature and progressive outward curving of both legs at the knees. Her medical history indicates that she is a picky eater and usually wears an abaya and headscarf when going out.

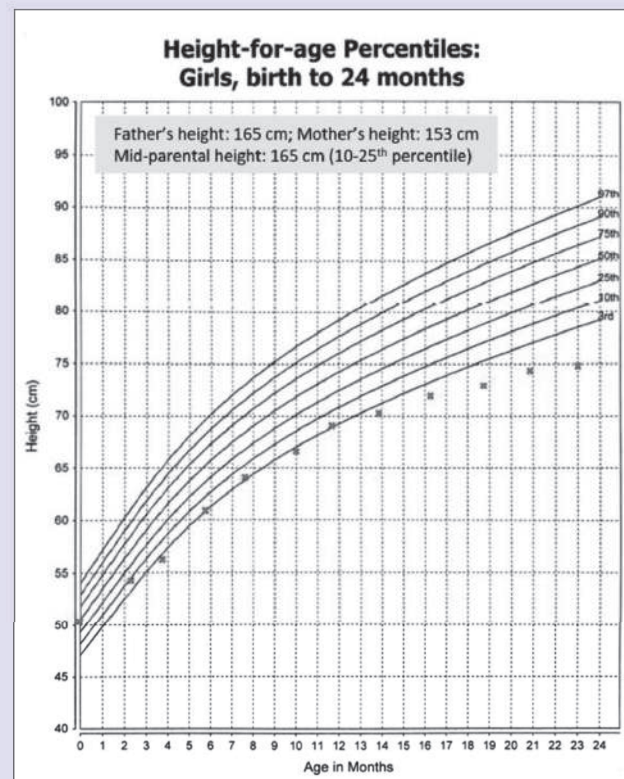


Figure 1. Growth chart for body height

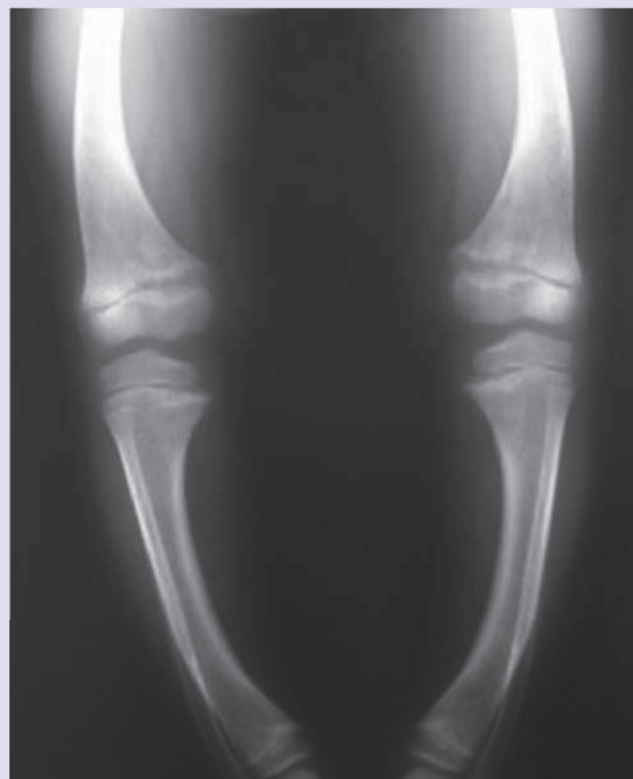


Figure 2. X-ray of both lower limbs

Q1. What is the most likely diagnosis?

- A. Physiological Bowing
- B. Blount's Disease
- C. Achondroplasia
- D. Nutritional Rickets
- E. Growth hormone deficiency

Q2. In a general context, which of the following factors is NOT associated with the development of the underlying disease?

- A. Premature birth
- B. Infant formula feeding
- C. Inadequate sunlight exposure
- D. Malabsorption disorders
- E. Dark skin complexion

Answers:

Nutritional rickets is caused by vitamin D deficiency (or calcium/phosphorus deficiency), leading to poor bone mineralization. It is a common cause of bilateral bow legs in children, especially in those with inadequate nutrition or limited sun exposure. A gradual decrease in height velocity often accompanies rickets due to poor bone development.

In contrast, physiologic bow legs are self-limiting and typically resolve by ages 2 to 3 years without affecting height velocity. Blount's disease, affecting the growth plate in the tibia, usually presents unilaterally and primarily impacts leg alignment rather than height. Achondroplasia is a genetic disorder marked by shortening of the proximal segment of limbs (known as rhizomelia) and disproportionately short stature, which is typically recognizable at birth or within the first few months of life. Growth hormone deficiency

may lead to decreased height velocity after age 3 but does not cause bow legs.

Various factors can contribute to vitamin D deficiency. Premature birth is a risk factor because premature babies tend to have lower vitamin D stores. Inadequate sunlight exposure and a dark skin complexion with higher melanin levels can limit the skin's ability to produce vitamin D from ultraviolet B rays. Malabsorption disorders may hinder the absorption of vitamin D from food. Additionally, prolonged exclusive breastfeeding without vitamin D supplementation can pose a risk, as breast milk alone typically does not provide sufficient vitamin D to meet an infant's needs unless the mother has adequate vitamin D level or the infant receives supplementation. Conversely, formula feeding is generally not a risk factor for nutritional rickets in children, as most commercial infant formulas are fortified with necessary vitamin D and calcium.



References

Munns CF, Shaw N, Kiely M, Specker BL, Thacher TD, Ozono K, et al. Global consensus recommendations on prevention and management of nutritional rickets. *J Clin Endocrinol Metab*. 2016 Feb;101(2):394-415.

Question 1 answer: D

Question 2 answer: B

Lung Function Test of a 64-year-old Man



Contributor: Dr. Julie KL Wang
王君玲醫生
Specialist in Respiratory Medicine

A 64-year-old Chinese man who is a chronic smoker for 30 years, presented with 1 year history of episodic cough and shortness of breath. He has kept a cat for last 10 years and has covid infection twice over last 2 years.

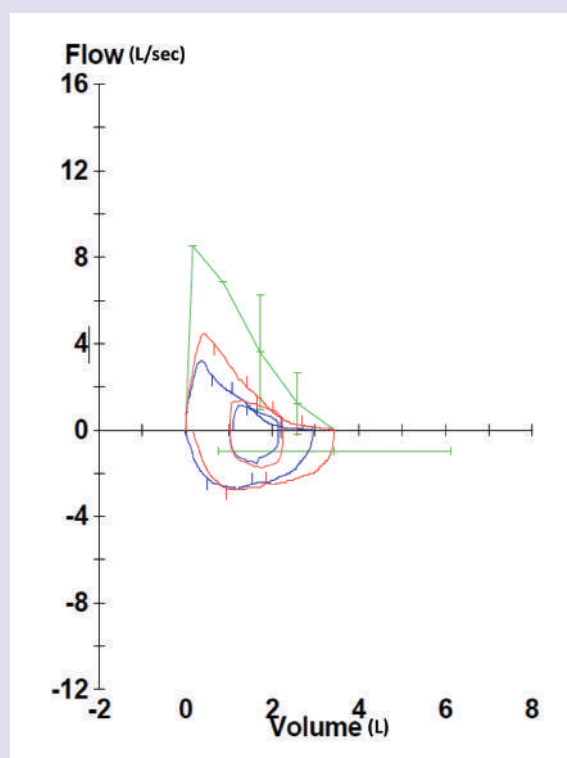
	Ref	Pre Bronchodilator (Pre-BD)	Predicted % Ref Pre-BD	Post Bronchodilator (Post-BD)	Predicted % Ref Post-BD	Post % Change
FEV1 (L)	2.60	1.69	65	2.05	79	21
FVC (L)	3.46	2.96	86	3.46	100	17
FEV1/FVC (%)	77	57	75	60	79	5

Q1. What is the finding of the spirometry ?

- A. Normal study
- B. Obstructive defect with significant bronchodilator reversibility
- C. Obstructive defect without significant bronchodilator reversibility
- D. Restrictive defect with significant bronchodilator reversibility
- E. Mixed obstructive and restrictive defect without significant bronchodilator reversibility

Q2. What is the diagnosis ?

- A. Normal
- B. Asthma
- C. COPD
- D. Concomitant asthma and COPD
- E. Concomitant asthma and bronchiectasis



Question 1 answer: B
Question 2 answer: D



The spirometry values show an obstructive defect with significant bronchodilator reversibility. An obstructive defect is demonstrated by $FEV1/FVC < 70\%$. A significant bronchodilator response is traditionally defined as an increase in FEV1 (forced expiratory volume in 1 second) and/or FVC (forced vital capacity) $\geq 12\%$ over baseline and $\geq 200\text{mL}$ (1).

The new definition of bronchodilator reversibility is an increase in FEV1 or FVC by greater than 10% of their mean predicted value (2).

The diagram on right side also illustrates bronchodilator reversibility, where the post bronchodilator flow volume loop (red loop) is larger than the pre bronchodilator flow volume loop (blue loop). The green loop represents the predicted flow.

This patient may be suffering from asthma alone or concomitant asthma and COPD. However, spirometry with bronchodilator response is not adequate to discern the 2 conditions. A full lung function test is needed.

Since this patient has a long standing smoking history, the additional assessment of static lung volumes and diffusing capacity are indicated.

An elevated TLC (total lung capacity), VC (vital capacity), RV(residual volume) and/or an impaired DLCO (diffusing capacity for carbon monoxide) would be compatible with COPD.

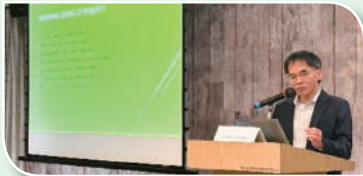
CT thorax would also be helpful to look for emphysema or bullous formation which are characteristic features of COPD.

References

1. Interpretative strategies for lung function tests. Eur Respir J. 2005;26(5):948
2. ERS/ATS technical standard on interpretive strategies for routine lung function tests. Eur Respir J. 2022; 60(1) Epub 2022 Jul 13

Past CME and Non-CME Activitites

Date	Topic	Speaker/s	Time & Venue
27 February 2025 (Friday)	Adult management of influenza and chest infection (Non-CME lecture)	Dr. Matthew King-yan WONG Specialist in Respiratory Medicine	Time: 1:00 pm - 2:30 pm Venue: Queen Victoria 8 (八公館)
 Dr. Jane Chan presented a souvenir to the speaker, Dr. Matthew King-yan Wong  Dr. Jane Chan presented a souvenir to the sponsor representative			
5 March 2025 (Wednesday)	Impact of influenza and the need for better influenza vaccines in the older adults (Non-CME lecture)	Dr. WONG King-ying Specialist in Respiratory Medicine	Time: 7:00 pm - 8:30 pm Venue: The Chinese Bank's Association Limited
 Group photo with the speaker, Dr. Wong King-ying and sponsor representatives  Q & A session moderated by Dr. Poon Man-kay			
7 March 2025 (Friday)	Role of Immunotherapy in Non-Small Cell Lung Cancer (NSCLC)	Dr. Carol Chi-hei KWOK Specialist in Clinical Oncology	Time: 1:00 pm - 2:30 pm Venue: Kwai Tsing District Health Centre (Core Centre)
 Dr. Henry Yeung and Dr. Carol Kwok presented a souvenir to the sponsor representative  Dr. Carol Kwok delivered the presentation			

Date	Topic	Speaker/s	Time & Venue
22 March 2025 (Saturday)	CME Series on Growth & Puberty Disorders: Growth Disorders Management	Dr. Sammy Wai-chun WONG Specialist in Paediatrics Dr. Aaron Chak-man YU Specialist in Paediatrics Dr. Betty Wai-man BUT Specialist in Paediatrics	Time: 1:00 pm - 3:00 pm Venue: Chalet, The Langham
 Q & A session moderated by Dr. Henry Yeung following the talks delivered by the speakers  Dr. Betty Wai-man But delivered the presentation  Dr. Jane Chan and Dr. Henry Yeung presented a souvenir to the sponsor representative  Dr. Sammy Wai-chun Wong delivered the presentation  Dr. Aaron Chak-man Yu delivered the presentation			
28 March 2025 (Friday)	Point-of-Care Testing Revolution: Enhancing Chronic Disease Management and Practice Efficiency in Hong Kong's Private Clinics (Non-CME lecture)	Dr. CHONG Man-Yuk CEO of JP Partners Medical Centre	Time: 7:00 pm - 8:15 pm Venue: The Chinese Bank's Association Ltd
 Dr. Jane Chan presented a souvenir to the sponsor representative  Group photo with the speaker, Dr. Chong Man-yuk after the talk			
5 April 2025 (Saturday)	CME Series on Growth & Puberty Disorders: Puberty Disorders Management	Dr. YAU Ho-chung Specialist in Paediatrics Dr. Anthony Chun-cheung FU Specialist in Paediatrics Dr. WONG Lap-ming Specialist in Paediatrics	Time: 1:00 pm - 3:00 pm Venue: Chalet, The Langham
 Group Photo with speakers and sponsor representatives  Dr. Wong Lap-ming delivered the presentation  Dr. Yau Ho-chung delivered the presentation  Dr. Anthony Chun-cheung Fu delivered the presentation			

Upcoming CME and Non-CME Activities

Date	Topic	Speaker/s	Time & Venue
16 May 2025 (Friday)	Update on Cardiac and Hypertension Management	Dr. Ivan Man-ho WONG Specialist in Cardiology	Time: 1:00 pm - 2:30 pm Venue: Queen Victoria 8 (八公館)
20 May 2025 (Tuesday)	A Paradigm Shift: Multidisciplinary Strategies for Early-Stage NSCLC with Perioperative Immunotherapy (Non-CME lecture)	Dr. Jeannie Yin-kwan CHIK Specialist in Clinical Oncology Dr. LI Ki-kwong Specialist in Cardio-thoracic Surgery	Time: 7:00 pm - 8:30 pm Venue: The Square, Exchange Square II
28 May 2025 (Wednesday)	RSV Prevention in 50+ adults with comorbidities (Non-CME lecture)	Dr. Ivan Man-ho WONG Specialist in Cardiology	Time: 1:00 pm - 2:30 pm Venue: Joy Cuisine (百樂門囍宴), Mei Foo
14 September 2025 (Sunday)	2025 Annual Scientific Meeting entitled Management of Chronic Diseases: Bridging Primary and Specialist Care	-	Time: 9:00 pm - 5:00 pm Venue: Cordis Hong Kong

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~~EXACERBATIONS~~
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~~ORAL CORTICOSTEROIDS~~



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REDUCTIONS in EXACERBATIONS AND OCS use were observed in patients with SEA with ≥ 150 cells/ μ L EOS.^{1,2,6}

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*Every 8 weeks following the first 3 doses Q4W.
bEOS, blood eosinophil; EOS, eosinophil; OCS, oral corticosteroid; SEA, severe eosinophilic asthma; Q4W, every 4 weeks; Q8W, every 8 weeks.
References: 1. Fasenra Pre-filled Pen HK Package Insert May 2021. 2. Korn S, et al. J Allergy Clin Immunol Pract. 2021;9(12):4381-4392. 3. Jackson DJ, et al. J Allergy Clin Immunol Pract. 2022;10(6):1534.e4-1544.e4. 4. Menzella F, et al. Respir Res. 2022;23(1):36. (Supplementary material). 5. Menzies-Gow A, et al. ERJ Open Res. 2019;5(3):00009-2019. 6. Menzies-Gow A, et al. Lancet Respir Med. 2022;10(1):47-58. 7. Menzies-Gow A, et al. Eur Respir J. 2022;60(6):2103226.
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Presentation: Benralizumab 30 mg solution for injection in pre-filled pen. Indications: Add-on maintenance treatment in adult patients with severe eosinophilic asthma inadequately controlled despite high-dose ICS/LABA. Dosage: Subcutaneous injection, 30 mg every 4 weeks for the first 3 doses, and then every 8 weeks thereafter. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Precautions: Should not be used to treat acute asthma exacerbations; Seek medical advice if asthma remains uncontrolled or worsens after initiation of treatment; Abrupt discontinuation of corticosteroids after initiation of Benralizumab is not recommended. Reduction in corticosteroid doses should be gradual and performed under the supervision of a physician; Patients with pre-existing helminth infections should be treated before initiating therapy of Benralizumab. Interactions: No formal drug interaction studies have been conducted. Cytochrome P450 enzymes, efflux pumps and protein-binding mechanisms are not involved in the clearance of Benralizumab. Undesirable Effects: Headache, pharyngitis, hypersensitivity reactions, pyrexia and injection site reaction. Full local prescribing information is available upon request. APIHK.FAS.0521
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寫在“2025 年電子健康紀錄互通系統（修訂）條例草案”刊憲後



林哲玄醫生
立法會議員

2025 年電子健康紀錄互通系統（修訂）條例草案（下稱條例草案）已於 2025 年 3 月 21 日刊憲並於 26 日於立法會首讀、二讀終止待續。28 日，內務委員會決定成立法案委員會審理條例草案，我已報名加入。是次修例引起業界憂慮，就此，我舉辦了三場研討會，香港中華醫學會是其中一場研討會的聯合舉辦機構。

醫健通+以“統一電子病歷”、“統一治理流程”、“統一健康工具”和“統一數據平台”為發展方向。是次修例目標有八：

1. 賦權醫務衛生局局長（下稱局長）可要求指明醫護提供者將已登記醫健通的病人的指明健康資料存入醫健通；
2. 修改醫健通的病人同意機制：簡而言之，病人只要簽妥參與同意，所有照顧該病人的醫護人員都可以將其健康資料存入醫健通，但是醫護人員必須得到病人的互通同意才可以瀏覽他在醫健通的資料；
3. 提供法律框架賦權局長指名某些文件只能通過醫健通發出；
4. 通過賦權電子健康紀錄專員按規則認可境外醫護提供者及其健康紀錄系統，方便病人在境外就醫時醫護人員可瀏覽他在醫健通的資料。

其他修改與醫生關係較疏離，以後再談。

同事最關注的莫過於法例賦權局長強制醫生將病人資料存入醫健通。病人的私隱、醫生所用系統的存入能力、存入的範圍、所產生的工作量和責任以及醫生的權利都成為激辯焦點。我先引述條例草案和政策文件為大家提供補充資料，理順已解決的部分，再梳理同事提出的具體問題綜合分析。

法例的執行

根據條例草案，局長可以通過條例的附表指明某類醫護提供者（例如私家醫院、地區康健中心、日間中心等）於規定的時間內上載指明之健康資料（例如診斷、藥物、過敏史、化驗報告等）。載列於附表上的要求即成為法例的一部分。電子健康紀錄專員可以在收到病人投訴時進行調查，及後對醫護提供者發出執行通知。專員可以對沒有按通知執行的醫護提供者發出定額罰款 1500 元，對仍不執行者可通過法律程序起訴，一經定罪，最高罰款 50000 元，及後沒有執行的日子每天附加罰款 1000 元。

病人私隱

政府的政策文件清楚寫明，“醫護接受者（病人）是其醫健通戶口及電子健康紀錄的唯一控制人”，“若醫護提供者（醫護人員）能證明病人明確要求醫護提供者不可向醫健通提供指明健康資料”，便是不存入料的辯護理由。而且，“如病人未有登記醫健通，此規定則不適用”。可以說，病人的私隱是原則上得到保障的。但是，技術上是否容許病人要求不存入某次就醫紀錄或某個疾病、某些藥物則有待確定。我們也必須考慮，隱藏的資料會否對病房、診所或手術室裡其他病人、醫護人員構成危險。

保險公司對醫療紀錄的解讀往往別樹一幟，10 年前一次簡單的胃疼可被解讀為今天胃潰瘍的復發，更由於病人 5 年前購買保險時沒有申報兒時的那次胃痛，現在被指為沒有披露重要資料，後果可能是索償時保單被取消。因此，社會以致醫生也十分關注保險公司可否在病人授權下瀏覽醫健通？答案是否定的。法例現時規定只有 13 類法定註冊醫護專業人員可取閱醫健通，條例草案增加 5 類認可醫療專業註冊計劃下的人士：臨床心理學家、教育心理學家、聽力學家、言語治療師和營養師，也不包括保險公司及其代理。當然，購買保險時那份沒有時間和範圍限制，對保險公司查閱病歷資料的授權仍然是病人頭上的一張利劍。

醫護提供者的資料存入能力

政府的政策文件清楚表明，“政府會確保醫護提供者在技術層面及實際運作上具備可提供有關健康資料的條件（包括必要的系統設置）”，才落實法例要求。

我收到醫生同事不少關注，例如數十年來一直以紙本書寫病歷、不諳科技、沒有寬頻、所用系統與醫健通不兼容，還有系統失靈時的責任、外洩病人資料時的責任、電腦系統報案的要求和責任等等。

醫健通不要求醫生使用單一系統存入資料，而採取與市場份額最大的商用系統協調，自動上載資料。系統包括醫健通提供的 CMS on-Ramp、香港醫學會的 CMS 4.0 和 5.0、Clinic Solution、Clinic One 以及 Apricot。現在前三者具備上載功能，Clinic Solution 具備部分上載功能，後兩者的上載功能有望在 2025 年內啟動。

業界關注

三次的研討會以及一週以來的通信，我收集了不少同業的關注。一些技術層面的問題已經與相關技術部門溝通，尋求解決方案。4 月 2 日我

致函醫務衛生局提出 10 個關注和問題如下：

1. 室官員、技術人員以及前線醫護人員或團體組成，適時就醫健通發展步伐、上載資料類別和上載程序共同商討、有效溝通，理順各關節問題；
2. 確保法律條文和實務方案有效防止資料被第三方（例如保險公司通過病人購買保險產品時簽訂的無時限及無指定範圍的醫療資料索取授權）向醫生索取整全病歷，侵犯病人隱私。
3. 政策文件指出病人有全權決定是否上載資料，我們也充分理解病人可能不希望家人、照顧者或醫護人員輕易看到一些敏感醫療信息，因而要求醫生不上載某次診症。由於上載功能是自動化的，醫生希望了解病人或醫生如何停止某次資料上載。有醫生建議醫健通手機程式增加功能讓市民對系統發出不上載指令，請當局探討技術可行性。當然，不上載某些重要資訊可能增加延誤診治的危機，落實與否務必謹慎。
4. 有醫生詢問上載的資料只包括病人表示同意之後的資料還是所有追溯得到系統內該病人的歷史資料都上載？
5. 有醫生認為重要資料（例如過敏史、慢重病診斷和治療）與輕病（普通感冒、腸胃炎等）資料應分別處理，例如只上載重要資料，否則系統裡資訊過多反而讓醫生失去焦點，延誤診治。
6. 有醫生關注系統的維護和資訊安全不是醫生的專業，是否醫健通辦公室可以提供協助。
7. 有醫生關注現在工作量大，新增要求不應該加重現有工作量；醫生特別關注系統速度和穩定性（例如當機的應變措施）。
8. 對於強制上載資料，醫生表示現有系統還未有上載能力（事實上市面常用的 3 個商用系

統之中，至今只有 1 個有限度提供上載（也不穩定，而其他系統正與政府商討），系統的責任不應落在醫生頭上。

9. 題希望政府關注和幫助，例如考慮系統提供簡單介面讓醫生輸入病人身份、診治日期時間、診斷、過敏史、藥物以及手動上載文檔等等。

10. 香港的家庭醫生分佈於社區的每個角落，有些地方至今未能安裝寬頻，包括偏遠地區和老舊區域。有醫生表示大廈業主立案法團拒絕所有鑽洞安裝光纖的申請，以致市中心區老舊大廈裡的商戶也只能使用較低速度的互聯網或無線寬頻。今天唯一有數據上載能力

的商用新版診所系統把所有病人資訊置於雲端，診所內沒有複本。要是診所沒有寬頻（無線寬頻速度不足也不穩定），就沒法順利使用新版系統，營運商也不會為醫生安裝。業界希望政府與營運商商討解決方案，例如病歷紀錄在診所備份，不時與雲端同步。

信函可以在此閱覽：<https://www.dr-davidlam.com/post/ehealth>

最後，我歡迎各位就此條例草案繼續表達意見和建議。

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Atopic Dermatitis (AD)

- Moderate-to-severe AD in adults and adolescents ≥12 years old[†]
- Severe AD in children 6 months to 11 years old[†]



Asthma

- In adults and adolescents ≥12 years old as add-on maintenance treatment for severe asthma with Type 2 inflammation^{*}
- In children 6 to 11 years old as add-on maintenance treatment for severe asthma with Type 2 inflammation[^]



Chronic rhinosinusitis with nasal polyposis (CRSwNP)

- As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP[#]



Prurigo Nodularis (PN)

- Moderate-to-severe PN in adults who are candidates for systemic therapy



Eosinophilic Esophagitis (EoE)

- In adults and adolescents ≥12 years old weighing ≥40 kg[‡]



Chronic Obstructive Pulmonary Disease (COPD)

- As add-on maintenance treatment with other medicines for adults with uncontrolled COPD[§]

[†] Candidates for systemic therapy

^{*} Characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment.

[^] Characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with medium to high dose ICS plus another medicinal product for maintenance treatment.

[#] For whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control.

[‡] Those who are inadequately controlled by, are intolerant to, or who are not candidates for conventional medicinal therapy.

[§] Characterised by raised blood eosinophils, on a combination of an inhaled corticosteroid (ICS), a long acting beta2-agonist (LABA), and a long-acting muscarinic antagonist (LAMA), or on a combination of a LABA and a LAMA if ICS is not appropriate.

Abbreviations: AD=atopic dermatitis; COPD = chronic obstructive pulmonary disease; CRSwNP= chronic rhinosinusitis with nasal polyps; EoE= eosinophilic esophagitis; FeNO=fractional exhaled nitric oxide; ICS=inhaled corticosteroids; LABA = long acting beta2-agonist; LAMA = long acting muscarinic antagonist; PN=prurigo nodularis.

References:

1. Guttman-Yassky E, et al. J Allergy Clin Immunol. 2019;143(1):155-172. 2. Gandhi NA, et al. Nat Rev Drug Discov. 2016;15(1):35-50. 3. DUPIXENT® Hong Kong Prescribing Information

Presentation: Dupilumab solution for injection in a pre-filled syringe with needle shield. **Indications:** Atopic Dermatitis (AD): Moderate-to-severe AD in adults and adolescents ≥12 years who are candidates for systemic therapy; severe atopic dermatitis in children 6 months to 11 years old who are candidates for systemic therapy. Asthma: In adults and adolescents ≥12 years as add-on maintenance treatment for severe asthma with type 2 inflammation characterised by raised blood eosinophils and/or raised FeNO, who are inadequately controlled with high dose ICS plus another medicinal product for maintenance treatment. In children 6 to 11 years old 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 medium to high dose ICS plus another medicinal product for maintenance treatment. For 300 mg only – Chronic rhinosinusitis with nasal polyposis (CRSwNP): As an add-on therapy with intranasal corticosteroids for the treatment of adults with severe CRSwNP for whom therapy with systemic corticosteroids and/or surgery do not provide adequate disease control. Prurigo Nodularis (PN): Moderate-to-severe PN in adults who are candidates for systemic therapy. Eosinophilic esophagitis (EoE): In adults and adolescents ≥12 years, weighing ≥40 kg, who are inadequately controlled by, are intolerant to, or who are not candidates for conventional medicinal therapy. Chronic obstructive pulmonary disease (COPD): In adults as add-on maintenance treatment for uncontrolled COPD characterised by raised blood eosinophils on a combination of ICS, LABA, and LAMA, or on a combination of LABA and LAMA if ICS is not appropriate. **Dosage & Administration:** Subcutaneous injection. AD adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg Q2W. AD adolescents (12-17y/o): Body weight <60 kg- initial dose of 400 mg (two 200 mg injections), followed by 200 mg Q2W. Body weight ≥60 kg- same dosage as adults. AD children (6-11y/o): Body weight 15kg–<60 kg- initial dose of 300 mg on Day 1 followed by 300 mg on Day 15, then 300mg Q4W. Body weight ≥60 kg- same dosage as adults. ^{*} The dose may be increased to 200 mg Q2W in patients with body weight of 15 kg–< 60 kg based on physician's assessment. AD children (6 months-5y/o): Body weight 5kg–15 kg- initial dose of 200 mg, then 200 mg Q4W. Body weight 15kg–<30 kg- initial dose of 300 mg, then 300 mg Q4W. 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 adults and adolescents: Initial dose of 400 mg, followed by 200 mg Q2W. For patients with severe asthma and on oral corticosteroids or with severe asthma and co-morbid moderate-to-severe AD or adults with co-morbid severe CRSwNP- initial dose of 600 mg, followed by 300 mg Q2W. Asthma children (6-11y/o): Body weight 15kg–<30 kg- 300 mg Q4W. Body weight 30kg–<60 kg- 200 mg Q2W; or 300 mg Q4W. Body weight ≥60 kg- 200 mg Q2W. For paediatric patients (6-11y/o) with asthma and co-morbid severe atopic dermatitis, as per approved indication, the recommended dose should follow AD children (6-11y/o). 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. CRSwNP: Initial dose of 300 mg, followed by 300 mg Q2W. Consider discontinuing treatment in patients who have shown no response after 24 weeks. PN: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg Q2W. Dupilumab can be used with or without topical corticosteroids. Consider discontinuing treatment in patients who have shown no response after 24 weeks. EoE: 300 mg QW. Dupilumab 300 mg QW has not been studied in patients with EoE weighing <40 kg. Dosing beyond 52 weeks has not been studied. COPD: 300 mg Q2W. Consider discontinuing treatment in patients who have shown no response after 52 weeks. For missed dose instructions, please refer to the full prescribing information. **Contraindications:** Hypersensitivity to dupilumab or any of the excipients. **Precautions:** Not be used to treat acute symptoms, acute exacerbations of asthma or COPD, 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. Cases of enterobiasis were reported in children 6 to 11 years old in the paediatric asthma development program. Advise patients to promptly report new onset or worsening eye symptoms. Patients who develop conjunctivitis, dry eye and keratitis that does not resolve following standard treatment should undergo ophthalmological examination. Sudden changes in vision or significant eye pain that does not settle warrant urgent review. Patients with comorbid asthma should not adjust or stop asthma treatments without consultation with physicians. Carefully monitor patients after discontinuation of dupilumab. Avoid using live and live attenuated vaccines concurrently with dupilumab. Patients should be brought up to date with immunisations before starting dupilumab. **Drug Interactions:** Immune responses to Tdap vaccine and meningococcal polysaccharide vaccine were assessed. Patients receiving dupilumab may receive concurrent inactivated or non-live vaccinations. **Pregnancy and lactation:** Should be used during pregnancy only if potential benefit justifies potential risk to foetus. Unknown whether dupilumab is excreted in human milk or absorbed systemically after ingestion. Decision must be made whether to discontinue breast-feeding or dupilumab taking into account benefit of breast feeding for the child and benefit of therapy for the woman. **Undesirable effects:** Most common adverse reactions reported- injection site reactions, conjunctivitis, conjunctivitis allergic, arthralgia, oral herpes, eosinophilia and injection site bruising. Safety profile observed in adolescents and children 6 months to 11 years old consistent with that seen in adults. 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.**

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MAT-HK-2400891-1-0-12/2024

Will the new public healthcare charge cause a butterfly effect to the healthcare system in Hong Kong?



Dr. Daniel WS Chu
朱偉星醫生
Specialist in Family Medicine



The new public healthcare charge scheme has been announced and will be implemented on the first day of coming new year 2026. This paper will focus on the relevant charges leaving the drug item charges to another discussion.

服務	2026 年旦起新收費	現行收費
住院費用（急症病床）入院費	取消	\$75
住院費用（急症病床）每天	\$300	\$120
住院費用（療養 / 復原、護養及精神科病床）每天	\$200	\$100
日間程序及治理（病床）入院費	取消	\$75
日間程序及治理（病床）每天	\$250	\$120
日間醫院（老人科、復康）	\$100	\$60
社康護理服務（普通科）、社區專屬醫療服務	\$100	\$80
社康護理服務（精神科）	免費	免費
精神科日間醫院	免費	\$60
急症室（非第 I、II 分流類別）	\$400	\$180
專科門診（包括專職醫療診所）首次及覆診	\$250	首次 \$135; 覆診 \$80
專科門診（包括專職醫療診所）每項藥物 *	\$20	\$15
病理檢驗服務（適用於專科門診）基礎項目	免費	免費
病理檢驗服務（適用於專科門診）進階項目	\$50	免費

Let's study the new charge proposal in detail. There are 2 types of charges: the first type involves a substantial increase from the original charge, and includes fees for daily in-patient stay, A&E visit, and GOPC (General Out-patient Clinic) & SOPC (Specialist Out-patient Clinic) visits as well as drug charge by item. The increases range from at least double to 5 times the original charge (for drugs). The second type involves newly introduced charges for pathology and imaging services.

On paper these changes are introduced with an aim to change the healthcare-seeking behaviour of Hong Kong residents so as to render public healthcare services more sustainable. The biggest change is the increase in A&E fee from \$180 to \$400, amounting to an increase by nearly 2.5 times. This fee is comparable to seeing a local community private doctor, connotating that such a change is intended to encourage a patient with a mild illness falling into the Category 4

or 5 of their A&E Triage system to go to seek medical attention from local community private doctors instead of going to A&E. I believe this will definitely move some patients to go to local private doctors but how significant the shift is has yet to be seen. One complicating consideration is the clinic operation time. Except for the 24-hour outpatient clinics operated by private hospitals, not many local private doctors continue their clinics beyond 9 pm, not to mention beyond 10 pm. We may still remember nearly 20 years ago the then-HKMA tried to run after-hour clinic in proximity to the A&E Centre of HA hospitals but the operation was not sustainable and had to be terminated in half a year's time. If one reviews the attendance record of A&Es at HA hospitals, the biggest turn-over is after dinner till mid-night. Unless there is a way to lure community private doctors to extend their practice beyond mid-night, the shift of patients from the HA A&E to the private clinics may be only fractional at best.

Another complicating consideration that drives Hong Kong residents to flock to the HA A&E centre is the all-inclusive services after paying the \$180 A&E charges, inclusive of blood tests, x-ray(s), and even expensive investigations such as CT scan. The new charges did attempt to address this point by stepping up charges for advanced (\$50) and high-end (\$200) items. Basic items are still free. The discrepancy in healthcare costs to the patient between private and public sectors is still so huge that such stepped-up charges will not sway the patients' direction to the private sector.

Let's take a look at the following scenarios:

First how many A&E attendees will need to undergo gene study for immune-related antibody? Where indicated, the price tag of \$50 at the HA is nothing, not to mentions the \$200 for gene sequencing, in contrast to the charges in the private market, where the charge is in the range of thousands to tens of thousands!

The same applies to HA imaging services, A \$250 charge for ultrasound or mammogram and a \$500 charge for CT or MRI is still a bargain for anyone who is familiar with the private market price. Such charging for the said investigations is comparable or even cheaper than going north into our Mainland!

Another target area is at the SOPC and GOPC services. The consultation fees have risen by 3 times from \$80 to \$250 and \$50 to \$150 respectively. The biggest impact is on the charge of drug, which will become by item and counted in per 4 weeks units with a maximum of 16 weeks' duration. For a SOPC patient over a 16-week period, each kind of drug will increase from \$15 to \$80. With SOPC so frequently prescribing over 10 kinds of medication, the drug charge will easily go above \$1000 per visit. The impact to GOPC patients is smaller with the currently free-of-charge drugs to \$5 per item per 4-week duration. Ten items for 16 weeks will mean \$200 in total, which is likely harmless as it is relatively affordable.

Will this change encourage SOPC patients to go to private doctors? My answer is NO, because the costs of medications prescribed by private doctors are much higher than those by the HA, even using the generic version. Private drugs cost more than HA SOPC drugs by at least one third or even 50%. Furthermore, there are other incentives for staying within SOPC system, such as the free basic blood tests, and, as discussed above, the fact that an "advanced" item is still much cheaper in comparison to the charges in the private sector.

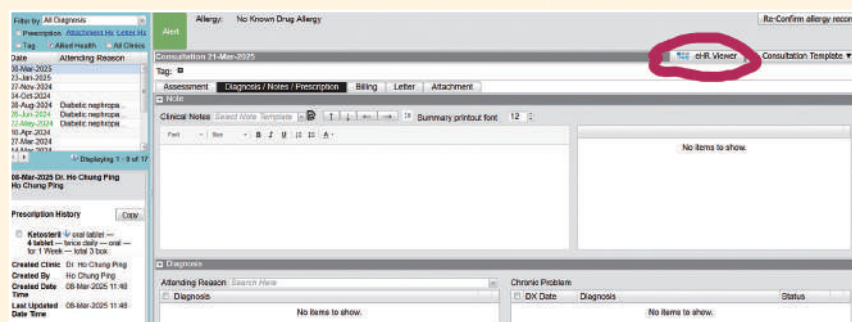
I do not know whether there is a hidden agenda from the HA to channel more patients into the PPP (Public Private Partnership) or CDCC (Chronic Disease Co-Care Program) program. If there is, will the drugs prescribed under the CDCC program follow the same charging principle as the newly introduced charging system, or the charges will still be free of charge. I cannot tell whether this is good or bad but my gut feeling and worry is that in longer run such changes may cause many problems and this is a topic for our community CDCC doctors to ponder and discuss.

In summary the new charges will stir up some dirt and muddle for a while but whether it will bring good to our healthcare system and how it will affect the public and private sectors is yet to be seen. My advice to doctors in the private sector, especially those in the primary care setting, is to "sit tight, hold the boat: a wave is coming."

How to upload patients' medical information to eHRSS



Dr. Chung-ping Ho
何仲平醫生
Specialist in Nephrology



The government is in the process of amending the eHRSS (electronic health record sharing system) Ordinance to enable the Secretary for Medical and Health to order a medical practitioner to upload medical information to the eHRSS, failing which a fine will be incurred. This causes worries and questions amongst medical practitioners, whose concerns include:

1. Uploading will further increase the workload of his/her practice.
2. Private doctors may not have the facilities nor experience to upload information as it is not part of their clinical duty. So far only 0.3% of the eHRSS data are uploaded by the private sector.
3. It is also not clear how the private practitioners can protect their patients' privacy and how to ensure proper ascertainment of patient's consent for any access to the patient's eHRSS data by any third party.

From a technical point of view, there are three ways to upload the medical data to eHRSS. Mode A is uploading of the medical data such as the laboratory reports and the discharge summary from the hospital information system to the eHRSS in a hospital setting. Mode B is for a private doctor to upload the information through a clinic management system (CMS) and again this can be done automatically. In mode C, doctors can directly key in information into the eHRSS system manually. Mode C is not ideal

because this will increase the workload of the medical practitioners and it could suffer risks of transcription errors. The data shared may not be standardized. Hence for private doctors, the preferred method is mode B.

As for the privacy issue, Hospital Authority (HA) patients give consent for HA staff ('upload consent') to upload their information to eHRSS when they seek treatment there. All HA doctors can see their records on a 'need to know basis'. At present, the patient has to give separate consent ('sharing consent') to empower private doctors to view and upload information to the eHRSS. In the future, the law may be changed so that 'upload consent' signed by the patient would allow private as well as HA doctors to upload the data.

Some colleagues felt that the government should provide the necessary software which is trustworthy, reliable and free of charge to medical practitioners. In fact, the HA has developed a CMS On-ramp system which allows the doctors to use in private clinics and will automatically upload the necessary patient data to eHRSS. The Hong Kong Medical Association (HKMA) further improved the On-ramp system and added a 'document management system' so that doctors could scan their paper records to migrate to digital version. This is called HKMA CMS 4.0 Nuwu 女媧 version and was released in 2016. Nuwu is the Chinese legendary goddess who worked with Fuxi 伏羲 to repair the hole in the

sky. Thus the pioneers chose the name Nuwu to denote the collaboration between the private and the HA sectors.

I have been using the HKMA CMS 4.0 Nuwu for the past few years. There is indeed a learning curve but that is the same in all CMSs. After I log into the system, I can ask the patient to give 'sharing consent' if he has not already done so. This is achieved by the patient handing to me his/her ID card to be inserted to the card reader for establishment of sharing consent. In this way, the process of obtaining consent takes minimal workload. Alternatively, I can print out the consent form for the patient to sign. The consent can be for one year or 'rolling consent' (i.e. permanent).

After "sharing consent" is established, an 'eHR viewer' button will appear and I can just click that button to have direct access to the eHRSS without the need to log into the eHRSS separately. It is most convenient especially nowadays when many patients attend the HA while also attending a private doctor's clinic for a 'second opinion'. The CMS is primarily for clinic management and there are areas for the users to enter the clinical notes, diagnosis, and the prescription. Data such as diagnosis and drug etc are standardized. If the patient is known to be allergic to certain drugs, this allergy information can be entered as well.



At regular intervals, the patient demographics, date of consultation ('encounter'), diagnosis, prescription and drug allergy will be uploaded to the eHRSS automatically. Do note that the dataset only covers the above items and NOT all data are uploaded to the eHRSS. I have found **this process user-friendly requiring no extra-work at all.**

From my personal experience, the HKMA CMS4.0 will improve the workflow in the clinic and will upload the necessary information to eHRSS without increasing the workload of the users. With the data uploaded, the eHRSS can produce a truly longitudinal medical record for each person in Hong Kong 'from the womb to the grave'. Apart from the HKMA CMS 4.0, the HKMA also developed the CMS 5.0 which also has Mode B upload capability. If the doctors are using other proprietary software (e.g. the ClinicSolution), to the best of my knowledge, the vendors are upgrading their system to enable Mode B upload as well. Maintaining good communication with the government and doctors will be essential and we are grateful that Dr Hon David Lam, our legal representative to the Legco, organised a seminar on the eHRSS ordinance amendment on March 25, 2025 with the HKCMA and 6 other medical associations. I feel that the CMS On-ramp is a time-proven system; for those doctors who wish to migrate to the system, the government should provide the software and technical support for the benefit of the society.

PS: I have uploaded a video to YouTube on medical data sharing based on my talk in the seminar for those who are interested in the details of the process.

<https://youtu.be/subATMJnZzM>



Highlights of the 2025 Annual Scientific Meeting



HONG KONG CHINESE MEDICAL ASSOCIATION LTD.

香港中華醫學會有限公司

14 September 2025, 0900-1700

Cordis Hong Kong (7/F & 8/F)

Chinese Academy of Engineering Academician Distinguished Lecture 中國工程院院士榮譽講座

Prof. HUANG Xiaojun 黃曉軍院士

中國工程院院士、北京大學血液病研究所所長、國家血液系統疾病臨床醫學研究中心主任

Dr. Alex NG 吳文達醫生

President, Tencent Healthcare

Topic: AI in Heath Care

Prof. Philip Wai-yan CHIU 趙偉仁教授

Dean, Faculty of Medicine, The Chinese University of Hong Kong

Topic: AI in Surgery

Prof. Gilberto Ka-kit LEUNG 梁嘉傑教授

Immediate Past President, Hong Kong Academy of Medicine

Topic: Clinical guidelines: do we have to follow them?

Prof. CHEN Rong-chang 陳榮昌教授

國家呼吸系統疾病臨床醫學研究中心副主任

Topic: Update on COPD

Prof. ZHANG Qingling 張清玲教授

廣州醫科大學附屬第一醫院呼吸內科主任醫師

Topic: Eosinophilic pulmonary disease

Prof. LIN Shuguang 林曙光教授

廣東省醫師協會前會長

Topic: 中國醫療改革之路：回顧及前瞻

Dr. Anthony Yiu-tung WONG 黃曜東醫生

Specialist in Cardiology

Honorary Clinical Assistant Professor, Department of Medicine, HKU

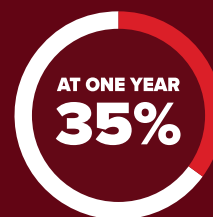
Topic: Personalized Strategies for CKD Management: A Holistic Cardio-Kidney-Metabolic Approach?

Make Clinical Remission a possible REALITI for your patients¹

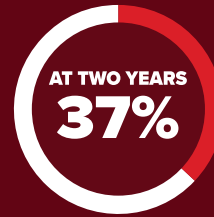
Images and patient profiles are for illustrative purposes only.

INTERNATIONAL REAL-WORLD REALITI-A STUDY:¹⁻³

Improved and sustained Clinical Remission rates in Severe Asthma* with Nucala (mepolizumab)^{1,2}



achieved Clinical Remission[†] on Nucala
(n/N=26/74) vs. 4% at baseline (n/N=3/72)[†]



achieved Clinical Remission[†] on Nucala
(n/N=19/52) vs. 2% at baseline (n/N=1/52)[§]

Four-component data: Exacerbation-free, mOCS-free, Asthma control, and lung function maintained[†] | Post-hoc analysis | Results are descriptive[†]

Primary endpoint of REALITI-A was met, rate of clinically significant exacerbations from the pre-treatment period at Year 1, was met: RR 0.29 (95% CI: 0.26–0.32); $p < 0.001$ [§]

ReThink Clinical Remission in Severe Asthma* and make Nucala your first-choice biologic today

^{*}For patients with Type 2 inflammation with an eosinophilic phenotype, in line with the Nucala label;^{†,§}Four-component Clinical Remission defined as meeting four criteria: 1) mOCS-free at time of assessment. OCS baseline defined as prednisone-equivalent dose in the 28 days prior, including Nucala start date. 2) No exacerbations requiring OCS and/or hospitalisation/emergency department visit during time of assessment. Exacerbation-free at baseline means exacerbation-free during the 12 months prior to Nucala initiation. Exacerbation-free at Year 1 and Year 2 means exacerbation-free for 12 and 24 months after Nucala initiation, respectively. 3) ACQ-5 score < 1.5 at time of assessment. 4) No worsening in FEV₁ from baseline (Nucala initiation) to time of assessment;[†]Analysis excludes patients with missing ACQ-5 and/or FEV₁ change from baseline at week 52. Of the 74 patients with ACQ-5 and FEV₁ results available at Week 52, six were missing ACQ-5 scores at baseline and were considered not in Clinical Remission at baseline;[†]Analysis excludes patients with missing ACQ-5 and/or FEV₁ change from baseline at Week 104. Of the 52 patients with ACQ-5 and FEV₁ change from baseline available at Week 104, five were missing ACQ-5 scores at baseline and were considered not in Clinical Remission at baseline.[†] ACQ-5, Asthma Control Questionnaire-5; CI, confidence interval; FEV₁, forced expiratory volume in the first second; (m)OCS, (maintenance) oral corticosteroid; RR, rate ratio.

References: **1.** Brusselle G, et al. Clinical Remission Achievement in Severe Asthma Following Mepolizumab Treatment: Results From the REALITI-A Study at 2 Years. Presented at: American Thoracic Society International Congress 2023. Poster 203. Available at: https://gskpro.com/content/dam/global/hcpportal/de_AT/Pdf/poster-203-brusselle-g-ats-2023.pdf. Accessed September 2024; **2.** Busse W & Chupp G. EMJ Respir. 2023;11(Suppl 1):2–10; **3.** Pilette C, et al. J Allergy Clin Immunol Pract.2022;10:2646–2656; **4.** Global Initiative for Asthma (GINA). 2024 Global Strategy for Asthma Management and Prevention. Available at: https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024-Strategy-Report-24_05_22_WMS.pdf. Accessed, September 2024; **5.** Nucala (mepolizumab) 100mg solution for injection in pre-filled pen Hong Kong Full Prescribing Information. Version: HK112021 (GDS14/EMA20211112).

Important Safety Information: Nucala (mepolizumab) 100 mg solution for injection in pre-filled pen (PI-HK112021 (GDS14/EMA20211112)) **Contraindications:** Hypersensitivity to the active substance or to any excipients of Nucala solution for injection. **Warnings and Precautions:** • Not to be used to treat acute asthma exacerbations. • Asthma-related adverse symptoms or exacerbations may occur during treatment. • Abrupt discontinuation of corticosteroids after initiation of Nucala therapy is not recommended. • Acute and delayed systemic reactions, including hypersensitivity reactions (e.g. anaphylaxis, urticaria, angioedema, rash, bronchospasm, hypotension), have occurred following administration of Nucala. • In the event of a hypersensitivity reaction, appropriate treatment as clinically indicated should be initiated. • Pre-existing helminth infections should be treated before starting Nucala. • Nucala has not been studied in patients with organ threatening or life-threatening manifestations of EGPA. • Nucala has not been studied in patients with life-threatening manifestations of HES. **Adverse Events:** Most commonly reported adverse reactions in: • Severe eosinophilic asthma: headache, injection site reactions and back pain. • CRSwNP: headache and back pain. • EGPA: headache, injection site reactions and back pain. • HES: headache, urinary tract infection, injection site reactions and pyrexia.

Abbreviations: CRSwNP, Chronic Rhinosinusitis with Nasal Polyps; EGPA, eosinophilic granulomatosis with polyangiitis; HES, Hypereosinophilic Syndrome.

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

For adverse event reporting, please email us at HKAdverseEvent@gsk.com or call (852)3189 8989.

Reporting forms and information can also be found at www.gskpro.com

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PM-HK-MPL-JRNA-240001 | October 2024 (September 2026)

NUCALA
mepolizumab

GSK





A Memorable Day Trip to Lai Chi Wo, Ap Chau, and Kat O with the Hong Kong Chinese Medical Association



Dr. Christopher KM Hui
許建名醫生

香港中華醫學會 (HKCMA) 的成員在蛇年展開了一次令人難忘的旅程。在香港繁忙的都會生活中，這次船遊為大家提供了一個放鬆心情、聯絡感情的機會。沿途的三地各具特色，每個目的地都充滿了探索的樂趣。

首先，荔枝窩的客家村莊有著傳統的建築和豐富的歷史。鴨洲是一個以天然美景聞名的小島。大家可以享受島上的新鮮海鮮，體驗道地的風味。最後，我們去了吉澳了解當地的漁民文化，並在廟宇前，為香港中華醫學會未來的一年祈福。

整天的旅途中，歡聲笑語不斷。大家不僅欣賞了沿途的自然風光，也深化了彼此的友誼。

文化，令我們更了解自己。亦都可以令我們放下手上的電子用品，互相交流，互相學習。加強會員對中國文化的認識與自信，才能更宣揚中國文化與故事。



On the crisp morning of Sunday, February 9, 2025, 70 doctors, family members, and friends from the Hong Kong Chinese Medical Association (HKCMA) gathered at the pier, eagerly anticipating a day of exploration, camaraderie, and cultural immersion.

Organized by the HKCMA's Social Committee, the day-long boat trip to the picturesque villages of Lai Chi Wo, Ap Chau, and Kat O promised a blend of natural beauty, historical discovery, and traditional cuisine. Led by Dr. Jane Chan, President of HKCMA, and Dr. Ho Chung Ping, Chair of the Social Committee, our group set off with high spirits, ready to create lasting memories.



Departure and Journey to Lai Chi Wo

The day began with a scenic boat ride from Hong Kong's bustling cityscape to the tranquil northeastern New Territories. As the boat glided across the shimmering waters, the group enjoyed breathtaking views of the coastline and the surrounding islands under perfect conditions and clear blue skies. Highlights along the coast introduced members of the group to special archaeological rock formations with interesting local names such as "Crouching Tiger", "Ghost Hand" and "The Face of Humanity".

Plover Cove Reservoir: Civil Engineering Marvel

As the boat passed the Plover Cove Reservoir, the group learned about this keystone infrastructure project up-close, from views of the main dam.

Plover Cove is the largest freshwater reservoir in Hong Kong. It was designed to solve the acute water shortages of a rapidly growing population throughout the early 1960's. It is the world's first freshwater coastal lake constructed entirely from an arm of the ocean.

Construction work commenced in 1960 and was completed in 1968, providing a capacity of 170 million m³. Work on raising the height of the dams began in 1970. Upon completion in 1973, the reservoir capacity was increased to 230 million m³.

The group learned that there are a total of 64 drainage channels along the main dam of the

reservoir, to safely manage circumstances of overflow or drainage.

Of its time, it was one of the most ambitious projects in the world. The main dam, which disconnected Plover Cove from the sea, was one of the largest in the world at the time of its construction.

Despite the construction cost of over \$348 Million dollars, together with \$60 Million dollars for the associated water distribution networks, it has long withstood the test of time to reflect the Hong Kong's ingenuity, resolve and focus in leveraging our common resources towards resolving essential societal problems of the era.

Reflections were made on how we should always retain our humble roots at heart to provide for the needs of everyone in society, much like we aimed to do then, today.

Lai Chi Wo: A Journey Through Time

The atmosphere was lively, with laughter and conversation filling the air. Ms. Iris Hau, the Secretary of HKCMA, ensured that everyone was well-informed about the day's itinerary, adding to the excitement and relaxed atmosphere.

The first stop was Lai Chi Wo, a 400-year-old Hakka village renowned for its well-preserved traditional architecture and lush surroundings. Upon arrival, the group was greeted by the village's serene ambiance and the sight of ancient Feng Shui woods, which are believed to protect the village and its inhabitants. A local guide shared fascinating stories about the village's history, including its agricultural heritage and the significance of its Feng Shui layout and significant historical trees. The group strolled through the narrow pathways, admiring the old stone houses, ancestral halls, and terraced fields. Many participants were particularly captivated by the village's harmonious coexistence with nature, a stark contrast to the urban environment they were accustomed to.



Exploring Ap Chau: The Island of Ducks

The next destination was Ap Chau, affectionately known as “Duck Island” due to its unique rock formations that resemble a duck’s profile. This small island, part of the Hong Kong UNESCO Global Geopark, offered a starkly different landscape from Lai Chi Wo. The group was fascinated by the island’s geological wonders, including the iconic Duck Rock and the layered sedimentary rocks that tell the story of millions of years of Earth’s history. A guided walk along the island’s trails provided insights into its ecological significance and the challenges of preserving such a fragile environment.

Participants also had the chance to interact with the local community, learning about the island’s history as a fishing village and its transformation into a popular eco-tourism destination. The visit to Ap Chau highlighted the importance of sustainable tourism and the need to protect Hong Kong’s natural heritage for future generations.

Traditional Lunch and Cultural Exchange

After the enriching tour of Ap Chau, the group returned to the boat to travel to the fishing village at Kat O for a traditional lunch prepared by local chefs. The meal featured an array of authentic Hakka dishes, including steamed fish, braised pork belly, stir-fried vegetables, and the iconic

Hakka stuffed tofu and meatballs. The flavours were a delightful revelation for many, offering a taste of the region’s culinary heritage. Dr. Jane Chan expressed her gratitude to the organizers and chefs, emphasizing the importance of preserving and celebrating Hong Kong’s local cultural traditions. The lunch was not only a feast for the palate but also an opportunity for the participants to bond over shared experiences and stories.



Kat O “Lucky Harbour” : A Glimpse into Fishing Village Life

After lunch, there was a tour of Kat O, also known as Lucky Harbour, a place steeped in maritime history and cultural richness. The group was welcomed by the sight of traditional houses and fishing boats bobbing in the harbour. A local elder shared captivating tales of the island’s past, including its role as a thriving fishing community and its unique customs and festivals. The visit to the Kat O Tin Hau Temple, dedicated to the Goddess of the Sea, was a highlight for many. The temple’s intricate architecture and spiritual significance offered a glimpse into the islanders’ deep connection to the sea.

As the sun began to set, casting a golden glow over the island, the group gathered for a group photos to commemorate the day. The serene beauty of Kat O provided a perfect backdrop for reflection on the day’s experiences and the bonds formed among the participants.

Reflections and Gratitude

As the boat made its way back to Hong Kong, the atmosphere was filled with a sense of contentment and gratitude. Dr. Jane Chan and Dr. Ho Chung Ping took a moment to thank everyone for their participation and enthusiasm, emphasizing the importance of such outings in fostering a strong sense of community within the HKCMA.

Dr. Jane Chan made introductions of the HKCMA Board and Council Members. Ms. Iris Hau also expressed her appreciation for the hard work of the guides and organizing committee, whose efforts ensured the day’s success.

The wheels of time never stop. Time, is indeed the greatest gift of all. This trip to Lai Chi Wo, Ap Chau, and Kat O was more than just a day out; it was a deeply meaningful celebration of Hong Kong’s rich cultural and natural heritage. It allowed us to briefly seek back and see clearly the wheels of time from whence we came.

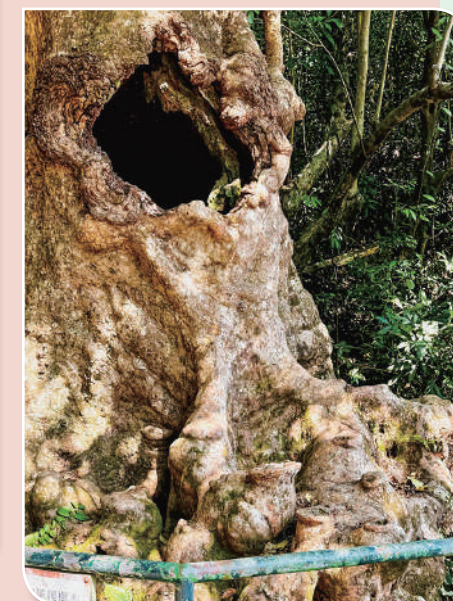
For the doctors, family members, and friends of the HKCMA, it was a reminder of the importance of stepping away from the demands of their profession to connect with nature, history, and each other. The shared highlights of the day—from the ancient trees of Lai Chi Wo, the geological wonders of Ap Chau, and the maritime traditions of Kat O all offered valuable lessons about the interplay between nature and health.

As the group disembarked, there was a unanimous sentiment that this day would be remembered as one of the most enjoyable and meaningful outings organized by the HKCMA.

The success of the event was a testament to the dedication of the organizers and the spirit of togetherness that defines the strength and determination of the HKCMA community. Until the next adventure, the memories of this happy day will continue to inspire and unite its members, reminding them of the enduring connections between culture, nature, and the healing arts!



Lai Chi Wo 荔枝窩



Ap Chau 鴨洲



Kat O 吉澳





Below are brief structured notes for visiting Lai Chi Wo, Ap Chau, and Kat O:

1) Lai Chi Wo

Overview: Lai Chi Wo is a historic Hakka village in Hong Kong's Plover Cove Country Park, part of the UNESCO Global Geopark. Known for its well-preserved village, fung shui woods, mangroves, and unique geology, it's ideal for cultural and nature enthusiasts.

Key Points:

- How to Reach There (Transport):
 - Ferry: Take a kaito ferry from Ma Liu Shui Landing No. 3 (near MTR University Station, Exit B, 15-min walk) on Sundays and public holidays at 9:00 AM (return at 3:30 PM). Round-trip costs ~HK\$90. Alternatively, on Tuesdays and Thursdays (except public holidays), ferries depart from Tai Shui Hang at 9:00 AM, passing Lai Chi Wo en route to Kat O and Ap Chau (fare: HK\$60-80).
 - Hiking: From Wu Kau Tang (accessible by Green Minibus 20R or KMB 275R from Tai Po Market), hike ~2 hours to Lai Chi Wo.
 - Sha Tau Kok: Daily ferries (except Tuesdays) from Sha Tau Kok Public Pier require a Closed Area Permit (HK\$60-80).
- Time to Spend on the Whole Itinerary:
 - ~6-7 hours, including ferry travel (1.5 hours each way from Ma Liu Shui) and 2-3 hours exploring the village, Lai Chi Wo Nature Trail, and Story Room. A full day is recommended if hiking from Wu Kau Tang or combining with other islands.
- Difficulty of the Walk:
 - Nature Trail: Easy to moderate, half-shaded, with flat sections and some steps. Suitable for those with basic fitness. The hike from Wu Kau Tang is moderate, with hilly and rock-paved paths (~1.15 hours).
- Other Useful Tips:
 - Visit the Lai Chi Wo Story Room (open 10:00 AM-4:00 PM, Sat/Sun, free) for heritage insights.

- Bring water and snacks; no reliable shops are available.
- Wear sturdy shoes for trails; mangroves and mudflats can be slippery.
- Check ferry schedules in advance; limited departures mean missing the return boat could strand you.
- Best visited October-March for cooler, dry weather

2) Ap Chau

Overview: Ap Chau, or "Duck Island," is Hong Kong's smallest inhabited island, famous for its ochre-colored rock formations, sea arch ("duck's eye"), and tranquil hiking. Part of the UNESCO Global Geopark, it's perfect for geology lovers and Instagram enthusiasts.

Key Points:

- How to Reach There (Transport):
 - Ferry: From Ma Liu Shui Landing No. 3 (near MTR University Station), take the kaito ferry on Saturdays, Sundays, and public holidays at 9:00 AM, arriving at Ap Chau via Kat O (~10:45 AM, 15-min ride from Kat O). Return departs Ap Chau at 12:30 PM to Kat O, then Ma Liu Shui by 5:00 PM (HK\$90 round-trip).
 - Alternative Routes: Tuesdays/Thursdays from Tai Shui Hang (HK\$60-80) or daily from Sha Tau Kok (Closed Area Permit required).
- Time to Spend on the Whole Itinerary:
 - ~1-2 hours on Ap Chau, as it's small (0.04 sq km) and walkable in ~1 hour. Including ferry travel (~2 hours total), plan 4-5 hours if visiting alone or 6-8 hours if paired with Kat O.
- Difficulty of the Walk:
 - Easy; coastal paths are flat and short, circling the island in ~1 hour. Suitable for all fitness levels, but rocky shores may be slippery

• Other Useful Tips:

- Visit the Ap Chau Story Room for geological and cultural insights (open weekends).
- Bring snacks/drinks; pop-up stores are unreliable.
- Wear sunscreen and hats; trails are exposed.
- Don't miss the 12:30 PM ferry from Ap Chau to avoid being stranded.
- Ideal for quick visits; combine with Kat O for a fuller day

3) Kat O

Overview: Kat O, or "Crooked Island," is a larger island with a crooked shape, offering scenic hikes, a Tin Hau Temple, and fishing village charm. Part of the UNESCO Global Geopark, it's great for history, nature, and casual exploration.

Key Points:

- How to Reach There (Transport):
 - Ferry: From Ma Liu Shui Landing No. 3, take the 9:00 AM kaito ferry on Saturdays, Sundays, and public holidays, arriving at Kat O ~10:30 AM (return at 3:30 PM, HK\$90 round-trip).
 - Other Options: Tuesdays/Thursdays from Tai Shui Hang (HK\$60-80) or daily from Sha Tau Kok (Closed Area Permit required).
- Time to Spend on the Whole Itinerary:
 - ~2-3 hours on Kat O, including the 1-km main trail (~30 mins), Tin Hau Temple, Story Room, and lunch at Yik Man restaurant. With ferry travel (~3 hours round-trip), plan 6-7 hours total, or a full day if combined with Ap Chau

• Difficulty of the Walk:

- Easy; the Kat O Natural Trail is short (~1 km, 30 mins), flat, and well-maintained, suitable for all ages. Some hilltop viewpoints may involve gentle climbs.

• Other Useful Tips:

- Dine at Yik Man, a family-run Cantonese eatery (cash only, set menu).
- Visit the Tin Hau Temple (built 1763) and Kat O Story Room for history.
- Bring cash (HK\$); no Octopus card or large bills accepted.
- Village stores are open mainly on weekends; bring water/snacks as backup.
- Check ferry times; the 3:30 PM return is the last from Kat O

General Notes:

- Combining Visits: Ap Chau and Kat O can be visited in one day using the Ma Liu Shui ferry, which stops at Kat O (10:30 AM), then Ap Chau (10:45 AM), returning via Kat O (3:30 PM). Lai Chi Wo is typically a separate trip due to its distinct ferry schedule or hiking access, but all three can be combined in a guided tour (e.g., via adventuretours.hk).
- Weather: Visit October-March for dry, cool conditions; avoid rainy seasons (April-September) due to slippery trails.
- Preparation: Wear comfortable shoes, bring sunscreen, water, and cash. Ferry schedules are limited, so plan carefully to avoid missing return boats.



HKCMA 9th FEBRUARY 2025 OUTING PHOTO CONTEST



Dr. Albert Yim-fai Kong
江炎輝醫生

Fostering Fraternity

At the Hong Kong Chinese Medical Association, nurturing fellowship among our members is one of the major objectives of our mission. We are dedicated to organizing vibrant social activities and special interest groups, providing opportunities for members and their families to connect, strengthen bonds, and forge lasting friendships—both new and old.

A Memorable Day on the Outlying Islands

On a radiant Sunday, 9.2.2025, over 70 HKCMA members, accompanied by families and friends, embarked on a chartered boat excursion to explore the serene beauty of Hong Kong's outlying islands: Lai Chi Wo, Ap Chau, and Kat O. The day was filled with laughter, exploration, and shared stories, culminating in an unforgettable journey. A vivid recount of this adventure, penned by Drs. Christopher Hui and Chloe Cheung, is featured on this page.

Capturing Moments, Creating Memories

To capture the splendor of the day and celebrate the joy of togetherness, a humble idea of a

small-scale photo contest was improvised, proposed on the spot and warmly endorsed by our HKCMA president. This impromptu initiative sparked enthusiastic participation. Despite its unplanned nature, the contest garnered over 70 heartfelt submissions, each reflecting the unique perspectives and cherished memories of our participants.

Judging and Winning

Judging was organised by Dr. Albert Kong, councillor HKCMA and accomplished by 3 distinguished HKCMA members, namely Dr. HO Chung Ping, councillor HKCMA, Dr. LEE Tze Yuen, vice president, The Photographic Salon Exhibitors Association, and Dr. WONG Man Kei, president, Doctors Photographic Association, smoothly on 21.3.2025 at Dr. Ho's office.

The results were as follows:

Champion: Dr. Norris LAI

First Runner-Up: Dr. Christopher HUI

Second Runner-Up: Dr. Shao Haei LIU

Honourable Mentions:

Dr. Norman CHAN

Dr. Chloe CHEUNG

Dr. Wai Sum LUK

Dr. Siu Kwan NG

Dr. Henry YEUNG

Each winner will receive a Certificate of Award and a supermarket coupon as a gesture of appreciation for his/her participation.

The winning entries along with other pictures are posted here to let readers share the joy and fun of the event.

WINNERS



CHAMPION

Author: Dr. Norris LAI

Title: Colorful memories



FIRST RUNNER-UP

Author: Dr. Christopher KM Hui

Title: Timeless Stone,
Ap Chau's Historic Arch



SECOND RUNNER-UP

Author: Dr. Shao Haei LIU

Title: 心亂如麻

HONOURABLE MENTIONS



HONOURABLE MENTION

Author: Dr. Norman CHAN

Title: 鬼手有若杏林之手，都要千錘百煉



HONOURABLE MENTION

Author: Dr. Chloe CHEUNG

Title: 家鄉麻糬 Mochi From Elderly's home



HONOURABLE MENTION

Author Dr. Wai Sum LUK

Title: 紅花盛開，春意盎然



HONOURABLE MENTION

Author: Dr. Henry YEUNG

Title: Ap Chau



HONOURABLE MENTION

Author: Dr. Siu Kwan NG

Title: One Dollar One Look



Author : Dr. Norris LAI

Title: Aerial Group Photo



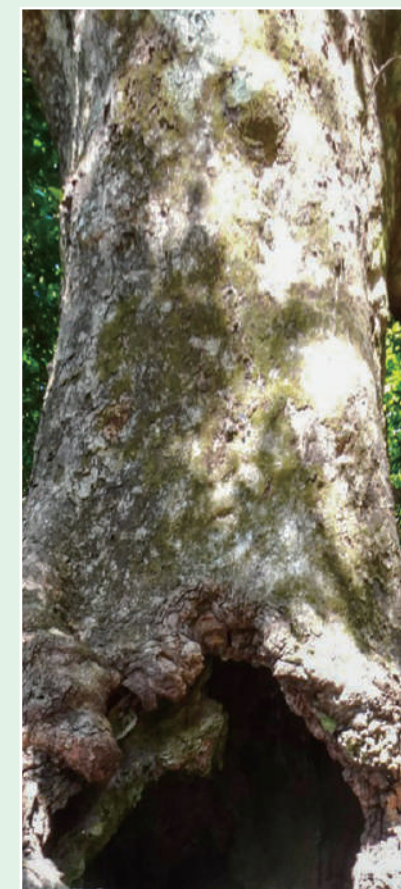
Author: Dr. Norris LAI

Title: 寶貴古蹟



Author: Dr. Henry YEUNG

Title: We Are Going Down



Author: Dr. Wai Sum LUK

Title: 無心樹守護者



Author: Dr. Christopher KM Hui

Title: Afternoon Wings - Sapphire Trails Afloat



Author: Dr. Norman CHAN

Title: 月掛中天暮未至，同伴天際任飛翔



Author: Dr. Shao Haei LIU

Title: 孤舟



Author: Dr. Sunny LUK

Title: 沐浴中的小綿羊



Author: Dr. Christopher KM Hui

Title: The Tree of Prosperity



Contest Judging Panel:

From left to right

Dr. Tze Yuen LEE, Dr. Albert KONG, Dr. Chung Ping HO, Dr. Man Kei WONG



HKCMA is inviting private general practitioners and relevant specialists to participate in this highly impactful "Chronic Kidney Disease Screening Programme" !

Join Us !



慢性腎病免費篩查計劃
Chronic Kidney Disease Free Screening Programme

香港中華醫學會舉辦
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Chronic Kidney Disease Screening Programme
spearheaded by Hong Kong Chinese Medical Association

計劃對象
年滿45歲至80歲人士及具有以下其中一個慢性病腎病高風險因素：

- 糖尿病
- 高血壓
- 高血脂
- 心血管疾病
- 有腎病家族史
- 肥胖 (身體質量指數≥30)

透過微白蛋白尿試紙，即場測試腎臟有沒有受損

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香港中華醫學會



Scan for registration
as participating doctor



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E-mail: info@hk-cma.org.hk

Website: www.hk-cma.org.hk

Address: Room 1612, 16/F, Central Building,
1-3 Pedder Street, Central, Hong Kong

HKCMA Membership Application



For Doctor



For Associate Member