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香港中華醫學會有限公司

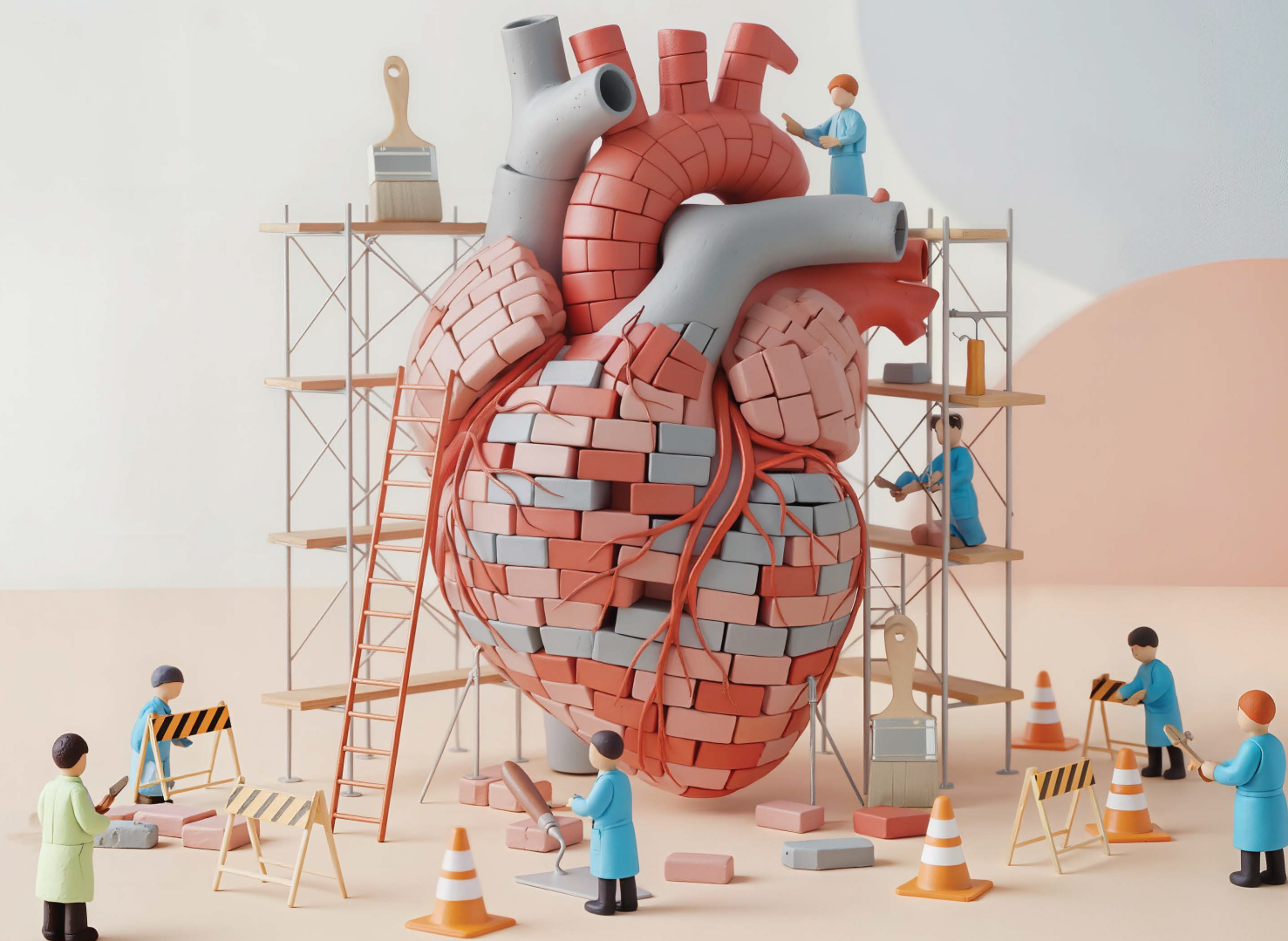
HKCMA *Bulletin*

香港中華醫學會會訊 HKCMA Bulletin

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心動不如行動

及早篩查，守護健康「心」生活





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香港中華醫學會 — 使命和願景

香港中華醫學會於 1995 年正式在香港註冊成為有限公司，時任會長為曹世植醫生，副會長為鍾尚志教授，秘書為沈祖堯教授。公司註冊處列明，香港中華醫學會的首四大宗旨如下：

- 促進醫療行業的福利和保護醫療行業的合法利益。
- 向公眾推廣和傳播醫學知識。
- 促進醫學科學的研究和工作。
- 促進和鼓勵醫學界成員之間的團結和友好關係。

HKCMA Vision and Mission

In 1995, the HKCMA Ltd. was formally registered as a limited company by guarantee. The first President of the registered company was late Dr. William Chao Sai-chik; the Vice- President was Professor Sydney Chung Sheung-chee; and the Honorary Secretary was Professor Joseph Sung Jao-yiu. The Memorandum of Association stated that the top four objectives of the HKCMA Ltd. are as follows :

- To promote the welfare and protect the lawful interests of the medical profession.
- To promote and spread knowledge of medical science among the public.
- To promote the study of and work for the advancement of medical science.
- To promote and encourage unity and friendly relationship among members of the medical profession.



Back row from the left : Dr. Ricky Chan, Dr. Albert Kong, Dr. Ho Chung-ping, Dr. Norman Chan, Dr. Poon Man-kay, Dr. James Wong, Dr. Chun-kong Ng, Dr. Catherine Chen, Dr. Kacey Hau, Dr. Paul Shea

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HKCMA Membership Application



For Doctor



For Associate Member



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Words from the Issue Editor



Dr. Catherine Xiao-rui Chen

Consultant Family Physician

Council member, HKCMA

A warm welcome to the April issue of Hong Kong Chinese Medical Association (HKCMA) Bulletin in 2026.

With the aging population and ever-increasing prevalence of chronic diseases such as diabetes and hypertension (HT), Hong Kong is facing with the unprecedented challenges from the high mortality from cardiovascular diseases (CVD). Under such context, we have chosen “**proactive control of cardiovascular risk factors**” to be the theme of this issue, aiming to alert all doctors on the importance of screening of high-risk patients and call for a concerted effort to stringently control the cardiovascular risk factors.

Obesity is a modifiable CVD risk factor and is highly prevalent in HK. According to the Department of Health's 2020-22 Population Health Survey, over half of local population is either overweight or obese. Obesity is closely associated with at least 24 conditions including CVD, and weight reduction could significantly reduce the complications from these conditions. In a press conference jointly organised by HKCMA, HK Obesity Alliance, the HK society for Metabolic and Bariatric Surgery and the HK Obesity Society, all experts highlighted the importance of having proper weight management and judicious use of weight reduction medications. A multi-pronged approach is proposed to ensure proper assessment and counselling for weight reduction.

Another important modifiable CVD risk factor is HT, and its resistant form, the resistant HT, is noted to be associated with even higher cardiovascular complications. In our CME articles, the proper diagnosis of resistant HT and the approach to differentiate it from apparent or pseudo-resistant HT is highlighted. All RH patients should be properly screened for the presence of a secondary cause and managed by a combination of healthy lifestyle interventions and a step-by-step adjustment of the antihypertensives. In recent years, several new drugs have been developed that may have a promising role in the treatment of resistant HT. These include endothelin antagonists, aldosterone synthase inhibitors and catheter-based renal denervation.

Lipoprotein(a) [Lp(a)] is an independent, inherited CVD risk factor that promotes the plaque formation. High concentration of Lp(a) is linked to early and premature onset of CVD. In the case study session, when to screen Lp(a) and how to interpretate the results are clearly illustrated. While no approved specialized drugs yet exist to specifically lower Lp(a), treatment focuses on aggressive reduction of other CVD risk factors, such as LDL cholesterol, blood pressure, and smoking cessation. Several specific medications that target Lp(a) are being tested in clinical trials and have demonstrated promising results.

We hope you find this issue of HKCMA bulletin educative and enjoy the well-designed topics and articles. Looking forward to seeing you all at other HKCMA CME or social activities.

Editor-in-Chief's Words



Dr. Kacey Kwun-cheung Hau 侯鈞翔醫生
Editor-in-Chief
HKCMA Bulletin
香港中華醫學會會訊主編

全城心動、每人只有一個心臟

有心事，誰能知？心臟問題，影響心深遠；也有諸多因素影響，成了心臟及血管疾病的高危因素。今期香港中華醫學會會訊，我們希望探討高血壓這個常見的都市疾病：有時並不是簡單吃藥，便能藥到病除的。高血壓不但造成心臟疾病的風險，也對眾多器官造成破壞，例如腎臟。早年內科工作時，曾見識過嚴重高血壓引致的視乳頭水腫，患者只有些許頭痛及「睇細嘢唔多清」，還一度要求出院，最後用多種方法穩定血壓後，經眼科同事評估已有永久視力傷害。今期家庭醫學專科兼會董陳曉瑞醫生的文章，值得一看。

心臟疾病這個都市病，離不開與身體其他狀況的息息相關。研究指肥胖引致二百多種疾病，當然包括心血管疾病。香港中華醫學會作為合作夥伴的《香港關注肥胖症聯盟》，最近召開的記者會，為健康體重管理提出了公眾指引。

肺炎鏈球菌引起嚴重呼吸道感染，特別是慢性阻塞性肺病 (COPD) 人士。我們有我們會長陳真光醫生、葉秀文教授、葉碧瑤教授、孔繁毅教授、古惠珊醫生、連慰慈醫生及吳振江醫生的專家團隊，為此作出深入回顧討論。

心血管疾病除了膽固醇，還有可怕的 Lipoprotein(a)。由心臟專科鄭裕康醫生的個案分享中可以學習；也有來自皮膚黎亦翹醫生的精彩分享。箇中答案？自己找找。

會刊一年多都在成長，多得各方幫助才成事。每年的重頭戲科研大會 (ASM)，值得關注。

立法會議員林哲玄醫生 - 2026 年 3 月工作報告 (醫療衛生界)



林哲玄醫生
立法會醫療衛生界議員

醫務委員會改革

醫務委員會改革已是如箭在弦，勢在必行。改革對醫生有甚麼影響？對病人有甚麼好處？據悉 改革有兩大方向，一是改組醫委會的組成，二是優化投訴機制。

改組醫委會

首先，業外委員對醫生的比例將有所增加，但料仍以醫生佔多數。醫生的選任委員人數和比例 將有所減少。此消彼長，委任的醫生有所增加。3 月 25 日立法會就改革醫委會議案進行辯論，有議員修訂議案增加業外委員至超過半數；可幸修訂以大比數否決，可見議會還是認同醫生應該專業自主。最後原議案在其他修訂後獲得通過。

黑外人士的角色

社會普遍要求增加業外人士比例，以提升對醫委會的監督。消其原因起於所謂「醫醫相衛」以及市民對延醫診治的不滿。不滿在於專科私家醫生和醫院費用高昂，以及公立醫院輪候期長。面對營運成本高昂，私家醫生也無可奈何；按醫保上限調整收費等個別行為確實也催化了社會對我們的懷疑態度。所謂「醫醫相衛」，表現在投訴後久久音訊杳然，查詢層服不果、等候遙遙無期，也表現在傳媒和市民對「除牌緩刑等於放過自己人」的負面印象。

業外人士有着監督醫委會的角色，也參與醫委會的決定和紀律聆訊的裁決。醫委會評審醫學院教學水準、釐定醫生的註冊水準要求，審批註

冊申請，並訂立醫生的執業守則。守則涵蓋醫患之間的界線、醫藥之間的關係、病歷記錄準則、藥物及手術治療的知情同意準則以及使用人工智能的責任歸屬問題等，須由行業決定。診斷、治療是否達到合理水平並非業外人士可以理解或判斷，因此，專業自主自律不可或缺。

還有三是調整特別註冊的適用範圍。改動或有助吸引非本地醫生來港服務，但我們必須堅持本地畢業醫生優先聘任、然後是非本地畢業的港人子弟。保護主義是盲目排他，寧可沒有服務都拒絕外來人才；保障本地青年事業機會和專業訓練，是任何城市的應有之義，不應曲解為保護主義。

為社福界設立「護理保健師」新專業職級的法例修訂

勞工福利局建議訓練資歷水準與登記護士相若的「護理保健師」職級，為安老及殘障院舍培養專門人才；建議於 3 月 16 日交福利事務委員會討論。護理保健師負責照顧院舍的住客，工作也 包括藥物注射、置換鼻胃喉和導尿管。放置鼻胃喉無急迫性、但有致命風險隱患，或應排除於工作範圍之外。所有護理程序須由專業醫護人員提供訓練、評估和監督。

就着上述關注我於 3 月 11 日去信勞福局，並於會議前與局方會面商討。局方確認訓練定必由相間專業人員提供，其程度和考核必與登記護士相同。護理保健師的工作範圍由駐院護士決定；一般而言，置換鼻胃喉等程序在醫管局社區老人評估小組 (CGAT) 或訪院醫生在場時方會進行。



立法會議員林哲玄醫生 - 2026 年 3 月工作報告 (醫療衛生界)

3 月 1 日	中醫醫院丙午年春茗
3 月 3 日	油尖旺區丙午年新春聯合團拜
3 月 6 日	「仁毅醫學教育計劃」面試
3 月 7 日	香港罕見疾病聯盟「世界罕病日研討會 2026」
3 月 8 日	浸會大學中醫藥學院丙午年新春茶聚
3 月 8 日	香港執業眼科視光師協會周年晚宴
3 月 9 日	新亞書院 / 耶魯大學交流活動 (YUNA) 2025/2026 歡迎晚宴
3 月 11-12 日	立法會會議
3 月 12 日	新亞書院 / 耶魯大學交流團立法會綜合大樓導賞團
3 月 12 日	就持續專業發展 (CPD) 平台與衛生署會面
3 月 12 日	香港眼科視光師學會周年晚宴
3 月 13 日	就為社福界設立護理保健師新專業職級的法例修訂與當局會面
3 月 13 日	油尖旺地區康健中心開幕典禮
3 月 14 日	健康灣仔智慧社區「肝好有您」活動
3 月 14 日	香港物理治療師協會周年晚宴
3 月 15 日	新華中醫中藥促進會五十周年金禧誌慶暨第十九屆理事會就職典禮
3 月 15 日	港九中華藥業商會七十五周年會慶暨第二十七屆會長理監事就職典禮及會員春茗聯歡晚會
3 月 16 日	福利事務委員會會議
3 月 16 日	就北部都會區專屬法例與當局會面
3 月 16 日	就基層醫療共同治理網絡接受香港電台《自由風自由 PHONE》訪問
3 月 16 日	「仁毅醫學教育計劃」行前簡介會
3 月 17 日	香港都會大學二零二五年度榮譽博士學位領受人晚宴
3 月 18-19 日	立法會會議
3 月 18 日	4th Meeting of Steering Committee, MSc in Dietetics Programme, Department of Food Science and Nutrition, The Hong Kong Polytechnic University

3 月 19 日	就當局擬收緊高齡職業司機體格檢測要求與職業治療師學會會面
3 月 19 日	將軍澳醫院醫院管治委員會會議
3 月 20 日	內務委員會會議
3 月 20 日	財務委員會會議
3 月 20 日	衛生事務委員會會議
3 月 20 日	交通事務委員會會議
3 月 20 日	就跨境醫療議題與科技大學學生會面
3 月 22 日	國際扶輪 3450 地區「獻血展全健——全健及捐血推廣日 2026」
3 月 24 日	就本港腦膜炎情況接受 TVB 訪問
3 月 25-26 日	立法會會議
3 月 25 日	就改革藥物審批制度進展及「藥械監管中心」立法建議與當局代表會面
3 月 25 日	就推廣母乳餵哺教育服務與專家會面
3 月 27 日	內務委員會會議
3 月 27 日	財務委員會會議
3 月 27 日	中文大學醫學院那打素護理學院「第八屆泛太平洋護理會議暨第二屆Cochrane 香港研討會」
3 月 29 日	新生精神康復會「330 感·生活『五感生活祭』典禮」
3 月 29 日	鷹君音樂兒童合奏團《星光傳承》音樂會
3 月 30 日	大灣區醫藥健康發展聯會「粵港澳大灣區醫療創新合作與交流高峰會」
3 月 30 日	國慶慶典第二次召集人會議



Hot Topics - 2026 Annual Scientific Meeting

A Warm Welcome Message - Invitation to the Annual Scientific Meeting (ASM) 2026



Dr. Catherine Xiao-rui Chen
Consultant Family Physician
Council member, HKCMA



Dr. Mike Yat-Wah Kwan
President, Asian Society for Pediatric Infectious Diseases (ASPID)

We are immensely honoured and pleased to welcome you all to attend the Annual Scientific Meeting (ASM) 2026 organised by the Hong Kong Chinese Medical Association (HKCMA) to be held on 6 September 2026 (Sunday) at Cordis Hotel, Hong Kong. This is the annual signature event of HKCMA, with esteemed guest, distinguished speakers and top scholars of various fields gathering together to share the latest advancement in one's expert fields. Over past years, HKCMA has strived arduously to unite leading minds, explore cutting-edge innovations, and enhance collaborations in the medical societies within Hong Kong and also serves as a bridge to connect with other medical societies in our country and the world.

As the world is recovering from the COVID-19 pandemic, we are navigating through the journey to evolving healthcare challenges from the aging population and another pandemic from the non-communicable diseases. Collaborations among different specialties and coming together to share knowledge and innovative solutions are more critical than ever before. Under such context, our organizing committee has chosen "Clinical excellence and advancement: Bridging Primary and Specialist Care" to be the theme of this year's ASM, aiming to providing an interactive platform to update all participants the latest advancement in hot topics and to achieve clinical excellence in different medical fields.

We are very much honoured have Dr. Pang Fei Chau as our Guest of Honor and he will enlighten us on government's vision and strategies in primary care development in Hong Kong. After the opening ceremony, Prof. Lu Lin, member of Chinese Academy of Sciences and world renowned psychiatrist, will deliver the "中國傑出院士講座". A wide spectrum of educative talks ranging from different vaccines such as RSV, COVID, HPV to cancer screening, dementia care and CKD management will be delivered by experienced local and overseas speakers. Furthermore, as point-of-care ultrasound is a safe, portable, and cost-effective tool for rapid bedside diagnosis, an ultrasound workshop with hands-on experience is organized to bridge basic science to clinical practice. Details of the scientific program will be announced in due course and please stay tuned.

We look forward to meeting you at the conference and wish you all an engaging, inspiring, and fruitful learning experience. Let us embrace this opportunity to learn, to network, and to work together to build a healthier and more resilient community in HK.

Hot Topics - Obesity Press Conference

香港關注肥胖症聯盟
HONG KONG OBESITY ALLIANCE

The “Hong Kong Obesity Alliance,” jointly established by the Hong Kong Chinese Medical Association, the Hong Kong Society for Metabolic and Bariatric Surgery, and the Hong Kong Obesity Society, held a press conference on 6 April 2026. Fifteen media outlets attended, and 22 media outlets carried extensive coverage.

Report highlights

Many people try different ways to keep fit and slim down before summer arrives; but blind dieting or using the wrong methods can backfire. The Hong Kong Obesity Alliance urges the public to manage weight properly and has noted that gray-market “slimming injections” are being sold online and that some slimming supplements contain banned Western drug ingredients—troubling trends. The Alliance reminds the public that safety must come first in weight reduction: medical weight management should be carried out under a doctor’s assessment and monitoring; do not self-medicate.

Health benefits of weight management

Obesity is a chronic disease and is associated with at least 224 conditions, including fatty liver and cardiovascular/cerebrovascular diseases. Citing research, Dr. Jane Chan, the President of the Hong Kong Chinese Medical Association and Specialist in Respiratory Medicine, said that if people with class III obesity (BMI ≥ 40 kg/m²) lose about 13% of their body weight, they can reduce the risk of multiple chronic diseases: the risks of type 2

diabetes and sleep apnea can drop by nearly 40%, while the risks of hypertension, hyperlipidaemia, and asthma can fall by nearly 20%.

Personalised treatment based on risk assessment

Dr. Simon Wong, the President of the Hong Kong Society for Metabolic and Bariatric Surgery and Specialist in General Surgery, reminded the public that before taking any anti-obesity medication or undergoing any treatment, a doctor’s individualised assessment is essential. Physicians will adjust or modify treatment plans based on weight-loss response and conduct personalized clinical evaluations, including the degree of obesity (BMI), the presence of obesity-related complications, causes of obesity, and contraindications to weight-loss drugs or surgery, in order to design the most suitable treatment strategy.

Do not self-medicate for weight loss

With the growing convenience of online shopping, the risk of improper access to prescription drugs has increased. The Alliance has noted five common problematic practices: self-medicating without medical evaluation; “supplements” on the market that contain prohibited Western drug ingredients that can harm health; drugs of unknown origin and counterfeits; mail-ordered slimming injections that may have problems during transport and storage—improper temperatures can contaminate or degrade the medication; and a

Hot Topics - Obesity Press Conference

lack of physician guidance, making it hard to adjust dosages promptly or handle emergencies.

Dr. Wong emphasised that individuals should undergo a physician’s personalized medical and risk assessment before starting pharmacotherapy. This helps ensure the use of legally sourced prescription medications, professional dosage management, and the establishment of a long-term monitoring mechanism.

A multi-pronged approach to weight control

In addition to using medications as prescribed, Dr. Michele Yuen, Founding President of the Hong Kong Obesity Society and Specialist in Endocrinology, Diabetes & Metabolism, noted that people trying to lose weight can also manage body weight and prevent related complications by keeping a food diary, avoiding binge eating, increasing physical activity, setting up an exercise

plan, and setting realistic weight-loss goals. Moreover, moderately increasing protein intake combined with regular resistance training and aerobic exercise can help reduce muscle loss while improving the effectiveness of weight-loss treatment.

Jo, a patient who participated in the press conference, had been referred for pre-operative medical assessment. She was to go through two-step surgery for her obesity-related back pain. As part of pre-operative optimisation, she started on biweekly slimming injections in September 2025. In 6 months, her weight dropped from 96 kg to 76 kg. After losing weight, her shortness of breath, joint pain, and back pain were significantly relieved, and her sleep quality improved. She continues to follow medical advice and adjust her diet, actively managing her weight in preparation for a healthy retirement.



From Left to Right
Dr. Michele Yuen (袁美欣醫生), Dr. Simon Wong (黃健鴻醫生), Patient Ms. Jo (Jo 女士), Dr. Jane Chan (陳真光醫生)

Media Report



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The Standard



Expert Dialogue on Pneumococcal Disease Prevention in COPD patients

At a recent expert meeting organized by the Hong Kong Chinese Medical Association, infectious disease specialists, pulmonologists and microbiologists discussed the evolving landscape of pneumococcal disease prevention in patients with chronic obstructive pulmonary disease (COPD).

Expert Panel:



Prof. Mary Sau-man Ip
Emeritus Professor and Honorary Clinical Professor, Division of Respiratory Medicine, LKS Faculty of Medicine, The University of Hong Kong



Dr. Jane Chun-kwong Chan
Specialist in Respiratory Medicine; President, The Hong Kong Chinese Medical Association; Honorary Clinical Associate Professor, Department of Medicine, LKS Faculty of Medicine, The University of Hong Kong



Dr. Ada Wai-chi Lin
Specialist in Infectious Disease, Hong Kong Sanatorium & Hospital; Co-chair, International Symposium on Antimicrobial Agents and Resistance (ISAAR 2026); Immediate Past President, The Hong Kong Society for Infectious Diseases



Dr. Fanny Wai-san Ko
Honorary Clinical Professor, Faculty of Medicine, The Chinese University of Hong Kong



Prof. Ivan Fan-ngai Hung
Chair Professor of Infectious Diseases & Vaccinology; Head, Division of Infectious Diseases, Department of Medicine, LKS Faculty of Medicine, The University of Hong Kong; Ru Chien & Helen Lieh Professor in Health Science Pedagogy



Prof. Margaret Ip
Professor and Chairman, Department of Microbiology, Faculty of Medicine, The Chinese University of Hong Kong; Deputy Director, S.H.Ho Research Centre for Infectious Diseases, Faculty of Medicine, The Chinese University of Hong Kong; Honorary Consultant, Department of Microbiology, Prince of Wales Hospital



Dr. Ng Chun-kong
Specialist in Respiratory Medicine, Honorary Clinical Associate Professor, Department of Medicine, LKS Faculty of Medicine, The University of Hong Kong

At the meeting, **Dr. Fanny Ko**, **Prof. Ivan Hung**, **Prof. Margaret Ip** and **Dr. Chun-kong Ng** shared their expertise in the field. Chaired by **Prof. Mary Ip**, they were joined by **Dr. Jane Chan** and **Dr. Ada Lin** on the panel, where they collectively offered insights into local practices and discussed ways to improve the current standards of care for preventing pneumococcal diseases in patients with respiratory issues, particularly those with COPD.

COPD and pneumococcal diseases

Dr. Fanny Wai-san Ko

Pneumococcal infections in patients with COPD

Patients with chronic lung disease have a higher chance of developing invasive pneumococcal disease (IPD) than healthy adults (incidence rate [IR]=62.9 vs 8.8 per 100,000 persons) and the risk increases with age.¹ Compared with healthy individuals aged ≥65 years, the incidence of pneumococcal pneumonia is 7.7 times higher in those with COPD in the same age group.² Moreover, among those who had COPD and concomitant pneumonia, *Streptococcus pneumoniae* was the most common bacteria (11.3%) identified in sputum samples collected.³

Pneumococcal vaccination in patients with COPD

A meta-analysis involving 2,171 patients with COPD demonstrated that pneumococcal vaccination reduced the likelihood of developing community-acquired pneumonia

(CAP) (OR=0.59; 95% CI: 0.41–0.85) and of an acute COPD exacerbation (OR=0.60; 95% CI: 0.39–0.93) compared to the control group, suggesting benefits of pneumococcal vaccination in patients with COPD.⁴

In the CAPiTA study, a randomized, placebo-controlled trial, the vaccine efficacy (VE) of PCV13 against vaccine-type CAP was 40.3% (95.2% CI: 11.4–60.2) among adults aged ≥65 years with risk factors, such as those with lung disease and asthma.^{5,6} Furthermore, immunogenicity results showed that the expanded-valency PCV20 elicited robust responses to all 20 vaccine serotypes in adults aged ≥18 years.⁷

Currently, the Global Initiative for Chronic Obstructive Lung Disease (GOLD) recommends pneumococcal vaccinations for all adults aged ≥65 years, and for those aged 19–64 years who have an underlying medical condition, including COPD.^{8,9}



Global IPD burden and prevention strategies

Prof. Ivan Fan-ngai Hung

Local IPD burden in adults

The distribution of pneumococcal serotype varies across different regions of the world.¹⁰ In Hong Kong, serotype 3 accounts for the majority of IPD cases (**Figure 1**).¹¹ In recent years, serotype replacement has been observed, with an increasing trend in IPD cases with PCV20-nonPCV15 unique serotypes, contributing to about 11.3% of IPD cases in the first half of 2025 (Jan–Jun).¹¹

Real-world effectiveness of PCV20

In a retrospective US cohort study, PCV20 demonstrated effectiveness against all IPD (VE=25.6%; 95% CI: 19.5–31.3) and all-cause pneumonia (VE=15.2%; 95% CI: 14.6–15.8) among adults aged ≥65 years.¹² Vaccination with PCV20 prevented 12.5 episodes of IPD per 100,000 person-years (95% CI: 9.2–15.8) and 262.0 episodes of all-cause pneumonia per 100,000 person-years (95% CI: 216.0–308.0).¹² PCV20 was also shown to be effective against these endpoints among PPSV23- and PCV13-naïve adults.¹²

Overseas recommendations for people with increased risk

Professional medical societies, including Global Initiative for Chronic Obstructive Lung Disease (GOLD), American Heart Association (AHA), and American Diabetes Association (ADA), recognized pneumococcal diseases as vaccine-preventable in

individuals with increased risk (i.e., patients with COPD, heart diseases, and diabetes).^{8,13,14}

The CDC also recommends vaccine-naïve adults aged ≥50 years and those aged 19–49 years with chronic health conditions (e.g., COPD and asthma) and specified immunocompromising

conditions to receive one dose of PCV20 or a dose of PCV15 followed by PPSV23.¹⁵

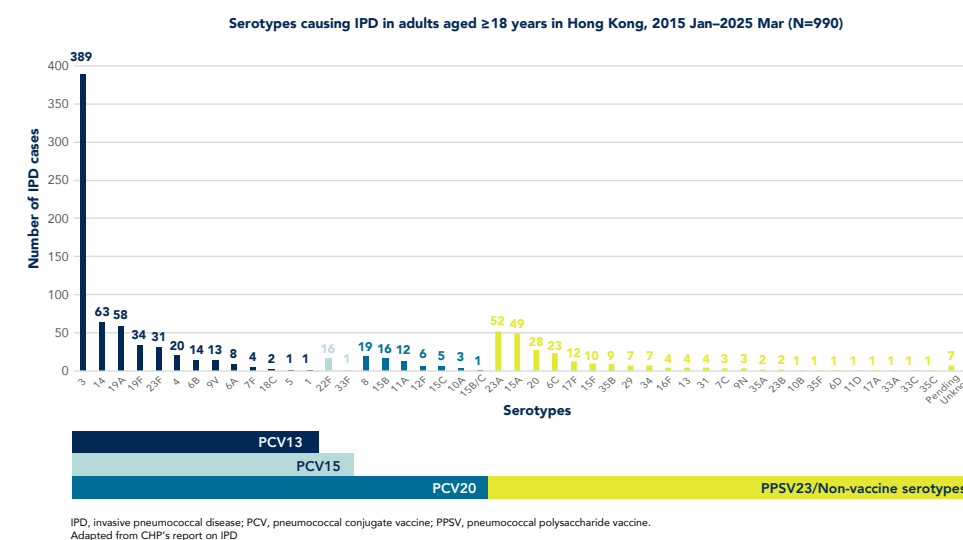
Expert insights on the role of pneumococcal vaccines locally*

PCV20 is currently favored by local experts due to its broader coverage of serotypes compared to PCV13 and PCV15.^{16,17*} Upcoming vaccines, such as PCV21 and PCV24, are expected to further expand serotype inclusion.^{18,19}

As observed in other regions where PCV15 has been in use for some time, experts anticipate a similar serotype replacement phenomenon to emerge locally in the future.* They also believe that PCV20 would remain a viable option in Hong Kong for another 2–3 years, after which newer vaccines with expanded valency (e.g., PCV24) may become necessary.*

*Based on experts' experience and opinion

Figure 1. Serotype distribution of IPD cases in adults aged ≥18 years in Hong Kong¹¹



Decoding Pneumococcus: Strains, diagnostics, and vaccines

Prof. Margaret Ip

Concerns with serotype 3

Despite being covered by PCV13, IPD caused by serotype 3 remains prevalent.²⁰ Serotype 3 capsule synthesizes via the synthase-mediated pathway, independent of the wzy-mediated pathway, which differentiates it from other pneumococci.²¹ Animal studies showed that serotype 3 releases significantly more capsular polysaccharide during in vitro growth and

infection.²² These soluble polysaccharides absorb anti-capsular antibodies, effectively impeding antibody-mediated killing of serotype 3 pneumococci in both in vitro and in vivo settings.²²

Studies also demonstrated that neutrophil-mediated opsonophagocytic killing only occur at high antibody levels.^{22,23} An in vivo study estimated that approximately 8 times more antibody is required to confer protection against serotype 3



Hot Topics - Pneumococcal Disease Prevention

compared to serotype 4 IPD.²² Notably, while clinical trials found that PCV15 elicited higher immunogenicity against serotype 3 than PCV13 in healthy adults, the level of immunoglobulin G geometric mean concentrations were comparable.²⁴

Expert insights on the management of pneumococcal diseases*

Serotype 3 is highly invasive and often associated with severe disease presentations, including meningitis, particularly in children.^{21,25,26} While its prevalence remains high,¹⁶ experts note that it is not significantly more difficult to treat compared to other strains.*

In terms of the need to serotype all patients in clinical practice, experts agree that identifying specific serotypes in patients with pneumococcal pneumonia is challenging due to technical limitations in culturing *S. pneumoniae*

These suggest that alternative immunisation approaches, such as protein-based or whole-cell vaccines, may be necessary to provide effective protection against serotype 3.²²

and the difficulties of collecting samples in children.^{27,28} Additionally, pneumococcus can recombine different capsule synthesis locus to produce new capsular types, contributing to the emergence of additional serotypes.²⁹ Experts hence emphasize the importance of enhancing surveillance systems to monitor the development of serotype replacement and antibiotic-resistant patterns.*

*Based on experts' experience and opinion

Preventing pneumococcal diseases in COPD patients

Dr. Ng Chun-kong

Challenges with current pneumococcal vaccines

Current vaccines do not cover all disease-causing serotypes and there is a lack of strong evidence supporting cross-serotype protection.^{30–32} However, adding more serotypes to vaccines will reduce the immunogenicity of each individual serotype.³² Serotype replacement can also occur when vaccines eradicate the predominant serotype, allowing non-covered serotypes to progress or flourish.³² Locally, the most common serotype has shifted from serotype 19F in the pre-PCV13 era to predominantly serotype 3 in the post-PCV13 era. Serotype 15 has also emerged as a non PCV13-covered serotype.²⁰

Furthermore, polysaccharide vaccines (i.e., PPSV23) lack long-term efficacy because they induce an immune response independent of the T-cell mechanism, with protection progressively waning over 5–10 years.^{33,34} In persons with certain underlying illnesses, elevated antibody levels decline more rapidly.¹⁸ PCVs also do not provide full (100%) protection against vaccine-type pneumococcal pneumonia or IPD.⁵

In terms of host-related factors, people with certain conditions may not mount adequate immune response after vaccination, including patients on immunosuppressants, individuals with medical illnesses (e.g., malignancy, chronic renal failure), infants and elderly.^{35–37}

Therefore, experts agree that future research should focus on developing vaccines with higher immunogenicity, broader serotype coverage and the ability to more precisely target circulating serotypes.* Identifying high-risk groups and exploring booster-dose strategies are also critical for optimizing vaccine efficacy.*

*Based on experts' experience and opinion

Barriers to vaccination among adults

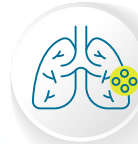
A low pneumococcal vaccination rate can result in reduced individual immunity towards *S. pneumoniae* infection, leading to higher risk of CAP, acute exacerbations of COPD, severe IPD, hospitalization, and mortality.^{4,5,38–40} It also reduces the clearance of colonization and hence interrupts the development of herd immunity.^{41–43}

*Based on experts' experience and opinion



Hot Topics - Pneumococcal Disease Prevention

Key takeaways



Individuals with chronic diseases, including COPD, are **at significant risk** of pneumococcal infection^{1,2}



PCV vaccination can⁴:
• Provide significant **protection against CAP** in COPD patients
• Reduce the likelihood of a **COPD exacerbation**



Raising public and physician awareness and **enhancing vaccine accessibility** are measures to overcome barriers and improve pneumococcal vaccination uptake*

*Based on experts' experience and opinion

¹As of 13 Oct 2025, compared with PCV13 and PCV15

²For adults, regardless of previous vaccination history

ADA, American Diabetes Association; AHA, American Heart Association; CAP, community-acquired pneumonia; CDC, Centers for Disease Control and Prevention; CI, confidence interval; COPD, chronic obstructive pulmonary disease; GOLD, Global Initiative for Chronic Obstructive Lung Disease; ICU, intensive care unit; IR, incidence rate; IPD, invasive pulmonary disease; OR, odds ratio; PCV, pneumococcal conjugate vaccine; PPSV, pneumococcal polysaccharide vaccine; VE, vaccine efficacy.

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For Healthcare Professionals only

"The Importance of Vaccines and Immunisation in Reducing Morbidities and Mortalities Caused by Infectious Diseases, and in Preventing Infectious Disease Outbreaks in the Community"

*Joint Statement
by*

The Asian Society for Pediatric Infectious Diseases (ASPID),
World Society for Pediatric Infectious Diseases (WSPID),
Asia Pacific Pediatric Association (APPA),
Hong Kong Chinese Medical Association Ltd,
2 members from the Legislative Council, HKSAR, China,
8 Paediatric Experts and 38 Scientific and Society organisations

20 March 2026

The human immune system is the body's defense mechanism against foreign threats such as viruses, bacteria, and parasites. Whenever these pathogens enter the body, the immune system responds by deploying its defenses to eliminate them. However, if the body has not previously encountered these pathogens, this process often takes longer, giving the pathogens more time to cause harm. This extended reaction time provides an opportunity for the pathogens to inflict damage, leading to adverse outcomes. The same process can result in severe illnesses, complications, and even death after infections with Measles, Hepatitis B virus, Diphtheria, Pertussis, Pneumococcus, SARS-CoV2, Influenza, and meningococcus, etc. These infections may also cause long-term health issues after recovery.

Vaccines play a crucial role in protecting individuals from serious diseases, infection complications, and even death caused by invasive pathogens. They are vital tools for preventing and controlling infectious disease outbreaks in communities.

Immunisation is also the foundation of primary health care and a proven strategy for enhancing population health.

The Asian Society for Pediatric Infectious Diseases (ASPID), World Society for Pediatric Infectious Organisation (WSPID), Asia Pacific Pediatric Association (APPA), Hong Kong Chinese Medical Association Ltd together with 2 members from the Legislative Council, Hong Kong Special Administrative Region, China, 8 paediatric experts and 38 scientific and society Organisations all around the world (please refer to the appendix), issue this joint statement to underscore the importance of vaccination in the eradication and control of infectious diseases. A historical example is smallpox, which the World Health Organization (WHO) declared eradicated in 1980. Once among the most devastating human diseases—with a mortality rate of approximately 30% from the variola major strain—smallpox caused severe complications, including skin scarring, blindness, and death. The successful eradication of smallpox

is one of the greatest achievements in public health and demonstrates the power of vaccination.

The measles virus is the world's most contagious virus, and measles is another vaccine-preventable disease that has been eliminated in many countries. Despite an existing vaccination program designed to prevent this disease, there has been a resurgence in various regions/countries due to the declining vaccination coverage. Those infected remain at risk of serious, acute, and/or lifelong complications such as blindness, pneumonia, encephalitis, and immune amnesia, which increases the susceptibility to other infections and the occurrence of Subacute Sclerosing Panencephalitis (SSPE).

Quoted from the World Health Organization (WHO), "Every death from a disease that could be prevented with a highly effective and low-cost vaccine is unacceptable".

Today, several infectious diseases, including infections caused by Hepatitis B virus (HBV), Respiratory Syncytial Virus (RSV), Influenza, Pertussis, Pneumococcus, and SARS-CoV-2 (COVID-19), remain widespread globally. HBV infection in children may lead to chronic infection and can progress to liver cirrhosis and hepatocellular carcinoma (HCC). RSV, Influenza, Pertussis, Pneumococcus and COVID-19 continue to cause significant morbidity and mortality among children, high-risk individuals, and the elderly population. Meningococcal disease is serious and can be fatal despite treatment. Vaccination remains the most effective way to prevent these infections and their severe complications and outcomes.

However, one of the growing challenges to public health is Vaccine Hesitancy, which is defined as the delay in acceptance or refusal of vaccines despite their availability and strong supporting

evidence. Changes in vaccine recommendations, misinformation, and public misunderstanding can contribute to increased "Vaccine Hesitancy". This has led to the resurgence of diseases that were once under control or eliminated. Measles is the example mentioned above.

We strongly urge the public to seek guidance from local health experts and to receive appropriate vaccines against vaccine-preventable diseases as soon as possible. We also call upon healthcare providers, experts in the field, and public health authorities to strengthen health education, communicate accurate information, and raise public awareness about the importance and safety of vaccines.

Citizens are encouraged to follow the evidence-based recommendations and advice of regional health authorities, professional experts, and societies in the field when selecting and scheduling the vaccines best suited to their needs and local health circumstances.

Members of the Asian Society for Pediatric Infectious Diseases (ASPID), World Society for Pediatric Infectious Diseases (WSPID), Asia Pacific Pediatric Association (APPA), the Hong Kong Chinese Medical Association Ltd. and the above professionals, scientific, and society organizations remain committed to working in accordance with the latest scientific evidence, particularly regarding vaccine development, recommendations, and implementation. ASPID will continue to collaborate closely with regional and international partners to monitor emerging infectious diseases, support effective immunisation programs, and promote vaccine confidence to protect the health of children and communities across Asia and the world.



Hot Topics - Vaccines & Immunisation



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Diseases



亞洲兒童傳染病學會
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Bangladesh Paediatric
Association



孟加拉兒科傳染病學會
Bangladesh Society for
Paediatric Infectious
Disease



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Pediatric Infectious
Diseases Society of
Thailand



韓國兒科傳染病學會
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of Indonesian Pediatric
Society



日本兒科傳染病學會
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Singapore Pediatric
Society



馬來西亞兒科協會
Malaysian Pediatric
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香港兒科護理學院
Hong Kong College of
Paediatric Nursing



澳門大健康醫療
發展學會
Macau Universal
Health and Medical
Development
Association



美國胸肺學院
(港澳分會)
Chest Delegation
Hong Kong and
Macau



港醫務委員會
執照醫生協會
The Association of
Licentiate of Medical
Council of Hong Kong



澳門兒科專科醫學會
Macau Pediatric
Society



香港醫學組織聯合會
The Federation of
Medical Societies of
Hong Kong



日本長崎大學
醫院兒科部
Department of Pediatrics,
Nagasaki University
Hospital, Japan



斯里蘭卡兒科醫學會
Sri Lanka College of
Paediatricians



巴基斯坦兒科協會
傳染病組
Infectious Diseases
Group, Pakistan
Pediatric Association



土耳其安卡拉哈塞特佩大
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Department of Pediatric
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香港微生物及
傳染病學會
The Hong Kong
Society for
Microbiology and
Infection



香港婦產科學會
The Obstetrical and
Gynaecological
Society of Hong Kong



香港中文大學健康
教育及促進健康中心
Centre for Health Education
and Health Promotion, The
Chinese University of Hong
Kong



糖尿病專家與
內分泌專家聯盟
Diabetologists &
Endocrinologists
Alliance



香港護理學院
College of Nursing
Hong Kong



香港兒科護士學會
Hong Kong Paediatric
Nurses Association



銀騎士
Silveriders



日本長崎大學醫院兒
科部川田宗一郎教授
Professor Soichiro
Kawata, Department
of Paediatrics,
Nagasaki University
Hospital, Japan



亞洲醫療專科學院
Asian Medical Expert
Academy



Professor
Shunmay Yeung
英國倫敦衛生與熱帶
醫學院傳染病與全球
健康教授，聖瑪麗帝國
學院醫院兒科傳染病榮
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香港呼吸科護理學會
Hong Kong
Respiratory Nursing
College



立法會陳凱欣議員
(選舉委員會)
Hon Chan Hoi-
yan, Member of the
Legislative Council
(Election Committee)



香港學校護士學會
The Hong Kong
School Nurses
Association Ltd

Professor Nigel Curtis,
墨爾本大學兒科傳染
病學教授，墨爾本皇
家兒童醫院傳染病科
學術負責人
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Hot Topics - Vaccines & Immunisation



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立法會(醫療衛生)
議員林哲玄醫生
Dr. Hon David LAM
Tzit-yuen, Member of
the Legislative Council
(Healthcare)



韓國首爾延世大學醫
學院 Severance
兒童醫院兒科傳
染病科李智英教
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國家兒童醫學中心
復旦大學附屬兒科醫
院感染傳染科謝新寶
主任醫師
Xie Xinbao,
Chief Physician,
Department of
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National Children's
Medical Center and
Children's Hospital
Affiliated to Fudan
University



香港助產士會
Hong Kong Midwives
Association



熊小麗，主任醫師
武漢兒童醫院
Xiong Xiaoli, Chief
Physician, Wuhan
Children's Hospital

兒童及青少年
皮膚科學會
Hong Kong Paediatric
and Adolescent
Dermatology Society



香港感染控制
護理師協會
Hong Kong Infection
Control Nurses
Association



香港幼兒教育
人員協會
Hong Kong Early
Childhood
Educators
Association

Appendix: The following experts, scientific and society organizations endorse this Joint Statement:

1. Asian Society for Pediatric Infectious Diseases 2. World Society for Pediatric Infectious Diseases 3. Asia Pacific Pediatric Association 4. Hong Kong Chinese Medical Association Ltd 5. Chinese Medicine Education Association 6. The Hong Kong Society for Paediatric Immunology Allergy and Infectious Diseases 7. The Hong Kong Society for Infectious Diseases 8. Asia Pacific Society of Clinical Microbiology and Infection 9. The Korean Society of Pediatric Infectious Diseases 10. Infection and Tropical Diseases Working Group of Indonesian Pediatric Society 11. The Pediatric Infectious Diseases Society of Thailand 12. Japanese Society for Pediatric Infectious Diseases 13. The Singapore Pediatric Society 14. Malaysian Pediatric Association 15. Pediatric Infectious Diseases Academy, India 16. Bangladesh Society for Paediatric Infectious Disease 17. Bangladesh Paediatric Association 18. Sri Lanka College of Paediatricians 19. Infectious Diseases Group, Pakistan Pediatric Association 20. The Hacettepe University Faculty of Medicine, Department of Pediatric Infectious Diseases, Ankara, Türkiye 21. Department of Pediatrics, Nagasaki University Hospital, Japan 22. The Hong Kong Society for Microbiology and Infection 23. The Federation of Medical Societies of Hong Kong 24. Macau Pediatric Society 25. The Obstetrical and Gynaecological Society of Hong Kong 26. Centre for Health Education and Health Promotion, The Chinese University of Hong Kong 27. Diabetologists & Endocrinologists Alliance 28. The Association of Licentiate of Medical Council of Hong Kong 29. Chest Delegation Hong Kong and Macau 30. Macau Universal Health and Medical Development Association 31. Hong Kong College of Nursing 32. Hong Kong College of Paediatric Nursing 33. Hong Kong Paediatric Nurses Association 34. Hong Kong Thoracic Society (Limited) 35. Dr. Hon David LAM Tzit-yuen, Member of the Legislative Council (Healthcare) 36. Hon Chan Hoi-yan, Member of the Legislative Council (Election Committee) 37. Dr. Vas Novelli, Consultant in Paediatric Infectious Diseases in Great Ormond Street Hospital, London, United Kingdom 38. Professor Nigel Curtis, Professor of Paediatric Infectious Diseases at the University of Melbourne and Academic Lead of Infectious Diseases at the Royal Children's Hospital Melbourne 39. Professor Shunmay Yeung, Professor in Infectious Disease and Global Health at the London School of Hygiene and Tropical Medicine and an Honorary Consultant in Paediatric Infectious Disease at St Mary's Imperial College Hospital, Paddington, United Kingdom 40. Dr. Xiong Xiaoli, Chief Physician, Wuhan Children's Hospital 41. Dr. Xie Xinbao, Chief Physician, Department of Infectious Diseases, Children's Hospital Affiliated to Fudan University 42. Dr. Ji Young Lee, Department of Pediatric Infectious Diseases, Severance Children's Hospital, Yonsei University College of Medicine, Seoul, Republic of Korea 43. Professor Soichiro Kawata, Department of Paediatrics, Nagasaki University Hospital, Japan 44. Professor Kamila Ludwikowska, Assistant Professor at Wrocław Medical University, Department of Pediatric Infectious Diseases, Wrocław, Poland 45. Hong Kong Infection Control Nurses Association 46. The Hong Kong Midwives Association 47. Hong Kong Respiratory Nursing College 48. The Hong Kong School Nurses Association Ltd. 49. Asian Medical Expert Academy 50. The Hong Kong Paediatric and Adolescent Dermatology Society 51. Hong Kong Early Childhood Educators Association 52. The Silveriders

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Hot Topics - 國情研習班

2026 深圳三天國情研習班 - 活動摘要



蔡振興醫生
香港急症醫學會前任會長

一、活動背景與目的

為加深香港醫衛界人士對國家發展大局的認識，並促進粵港澳大灣區醫療衛生合作，「香港醫衛界國情班同學會」於 2026 年 4 月 17 日至 19 日，假深圳紫荊山莊舉辦了為期三天兩夜的國情研習班。本次活動共匯聚 43 名跨界別醫衛專業人士（包含西醫、牙醫、脊醫、中醫、護士及醫療管理人員），透過實地考察與專題授課，旨在拓寬業界視野、建立人脈網絡，並探討香港醫療界在國家戰略中的角色定位。

二、核心活動內容

本次研習班採取「理論與實踐並重」的模式：

- **實地考察：**參觀了騰訊、大疆無人機及邁瑞醫療等龍頭科創企業，親身感受國家在數字化轉型、人工智能及高端醫療器械領域的高速發展與硬實力。
- **專題授課：**邀請專家深入講解《一國兩制與國家安全》、《十五五規劃與香港機遇》及《粵港澳大灣區醫療衛生協作》，幫助學員掌握國家宏觀政策與行業發展脈絡。

三、學習成果與問卷反饋

活動後回收的 43 份問卷（回收率 100%）顯示，研習班取得極高評價：

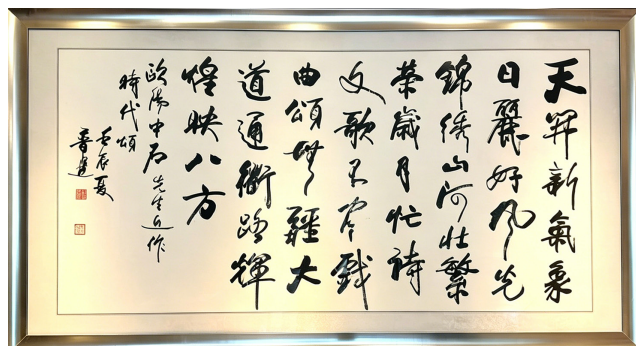
- **高度滿意：**整體滿意度高達 4.86/5 分，97.7% 參加者認為成功「開拓視野」，76.7% 成功「建立人脈網絡」。
- **實踐轉化：**超過六成學員表示會將所學應用於「工作／業務策略規劃」（66.7%）及「融入大灣區及國家發展大局」（61.5%）。

- **核心共識：**學員提煉出的最核心心得為「安全是發展的前提」（23.3%），並深刻認識到香港必須主動融入國家大局。
- **優化建議：**參加者普遍期望未來活動能增加「學員互動／小組討論時間」（27.9%），以及適當「延長研習天數」（16.3%）。

四、關鍵洞察與反思

根據學員的學習心得總結，香港醫衛界在未來發展中應聚焦以下方向：

1. **善用獨特優勢：**發揮香港在「一國兩制」下的國際化、專業化優勢，擔當「超級聯繫人」與「超級增值人」，協助國家高端醫療器械「走出去」及引入全球資源。
2. **科技與醫療融合：**借鑒內地科創企業經驗，積極探討 AI、大數據及無人機等新質生產力在香港及大灣區醫療服務中的落地應用。
3. **對接國家規劃：**把握「十五五」規劃機遇，積極參與「健康中國」建設及大灣區跨境醫療協作（如「港澳藥械通」、臨床試驗平台及人才交流）。



BEXSERO
Meningococcal Group B Vaccine
(rDNA, component, adsorbed)

JOINT CONSENSUS: APAC countries should consider adding MenB Vaccination in their Immunization Programs¹



HKCHP NEWLY RECOMMEND meningococcal vaccine for **TRAVELLERS** to epidemics or outbreaks area²



MENB IS EMERGING WORLDWIDE^{1,3}

WORLDWIDE DISTRIBUTION OF NEISSERIA MENINGITIDIS SEROGROUPS^{1,3-9}



High-risk Groups¹⁰⁻¹²



Infants



Toddlers



Adolescents



Travellers

Complications¹⁰



Mortality rate as high as **16%**



20% suffer from severe complications - including amputation, hearing loss, disability, brain damage



Fatal in **24 hours**

Bexsero is indicated for active immunisation of individuals from 2 months of age and older against invasive meningococcal disease caused by Neisseria meningitidis group B.¹

APAC-Asia Pacific Accreditation Cooperation; HKCHP-Hong Kong Centre for Health Protection
References: 1. Liu G, et al. Hum Vaccin Immunother. 2025;21(1):1-12. 2. Centre for Health Protection. Available at: <https://www.chp.gov.hk/en/healthtopics/content/24/2086.html>. Accessed Sep 2025. 3. Au A, et al. Communicable Diseases Watch. 2025;25(1):25-31. 4. Centers for Disease Control and Prevention. 2019. Available at <https://www.cdc.gov/meningococcal/downloads/NCIRD-EMS-Report-2019.pdf>. Accessed Sep 2025. 5. Public Health Agency of Canada. 2022. Available at <https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/vaccines-immunization/acscn-preventable-disease-surveillance-report-2019-vaccine-preventable-disease-surveillance-report-eng.pdf>. Accessed Sep 2025. 6. UK Health Security Agency. Available at <https://www.gov.uk/government/publications/meningococcal-disease-laboratory-confirmed-cases-in-england-2023-to-2024/laboratory-confirmed-cases-of-invasive-meningococcal-infection-in-england-july-to-september-2023>. Accessed Sep 2025. 7. European Centre for Disease Prevention and Control. Strep-hem: ECDC, April 2024. Available at <https://www.ecdc.europa.eu/en/default/files/documents/invasive-meningococcal-disease-annual-epidemiological-report-2022.pdf>. Accessed Sep 2025. 8. Lahra MM, et al. Communicable Diseases Intelligence. 2024;48(1):5. 9. Institute of Environmental Science and Research Limited. ESR. January 17, 2024. Available at <https://www.esr.cri.nz/digital-library/meningococcal-disease-report-an-dec-2023/#--lead=This%20report%20summarises%20invasive%20meningococcal%20disease%20notifications%20and%20Meningococcal%20reference%20laboratory%20as%20a%20a%2017%20January%202024>. Accessed Sep 2025. 10. World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/meningitis>. Accessed Sep 2025. 11. Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/meningococcal/risk-factors/index.html>. Accessed Sep 2025. 12. Peterson ME, et al. J Glob Health. 2016;6(1):010409.
Safety Information:
Hypersensitivity to any components of BEXSERO is a contraindication to administration. Administration of BEXSERO should be postponed in subjects suffering from an acute severe febrile illness. Minor infection, such as cold, should not result in the deferral of vaccination. BEXSERO should not be given to individuals with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection, unless the potential benefit clearly outweighs the risk of administration. Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic event following administration of BEXSERO.
Anxiety-related reactions, including vasovagal reactions (syncope), hyper-ventilation or stress-related reactions may occur in association with vaccination as a psychogenic response to the needle injection. It is important that procedures are in place to avoid injury from fainting. The safety and efficacy of BEXSERO in individuals above 50 years of age has not been established. There are limited data in patients with chronic medical conditions. In immunocompromised individuals, vaccination may not result in a protective antibody response. Insufficient clinical data on exposed pregnancies are available and there are no data on fertility in humans.
BEXSERO is not expected to provide protection against all circulating meningococcal group B strains.
The most common adverse reactions observed in clinical trials of infants and children were tenderness and erythema at the injection site, fever, and irritability. Fever occurred more frequently when BEXSERO was co-administered with other routine infant vaccines than when it was given alone.
Higher rates of antipyretic use were also reported for infants vaccinated with BEXSERO and routine vaccines. When BEXSERO was given alone, the frequency of fever was similar to that associated with routine infant vaccines administered during clinical trials. When fever occurred, it generally followed a predictable pattern, with the majority resolving by the day after vaccination.
Prophylactic use of paracetamol reduces the incidence and severity of fever without affecting the immunogenicity of either BEXSERO or routine vaccines. Antipyretic medication should be initiated according to local guidelines in infants and children (less than 2 years of age). Due to an increased risk of fever, tenderness at the injection site, change in eating habits and irritability when BEXSERO was co-administered with routine vaccines, separate vaccinations can be considered when possible.
In adolescents and adults, the most common local and systemic adverse reactions observed were pain at the injection site, malaise and headache.
Less commonly, some serious events can occur after BEXSERO: seizures (including febrile seizures) and allergic reactions.
Please read the full prescribing information prior to administration.
Full prescribing information is available upon request at GlaxoSmithKline Limited - 1004-1010, 10/F, Tower 6, The Gateway, 9 Canton Road, Tsimshatsui, Kowloon, Hong Kong.
The material is for the reference and use by healthcare professionals only.
For adverse event reporting, please call GlaxoSmithKline Limited at (852) 3189 8987 (Hong Kong) (or (853) 2871 5569 (Macau)), or report via online Patient safety reporting form: <https://gsk.public.reporting.com/>.
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PM-HK-BEX-PSTR-250001 (08/2027). Date of preparation: 09/2025



Reflections on a Journey of Professional Discovery in the Greater Bay Area



Dr. Ludwig Chun-hing Tsoi
Former President, Hong Kong Society for
Emergency Medicine and Surgery (HKSEMS)

In the golden light of April 2026, a group of 43 healthcare professionals from Hong Kong—medical doctors representing diverse specialties, alongside colleagues from dentistry, nursing, and healthcare management—embarked on a transformative three-day journey to Shenzhen. Organized by a bunch of healthcare professionals who are also the alumni of "Guoqing Ban", this retreat From 17 to 19 April 2026 at the serene Bauhinia Villa was more than an academic exercise; it was a joyful reunion of minds and a profound exploration of our shared future within the Greater Bay Area (GBA).

As members of the Hong Kong medical community, we have long prided ourselves on our rigorous training and international outlook. This trip, however, offered a fresh lens through which to view our professional identity—not just as practitioners in a bustling metropolis, but as key contributors to a national health vision that is rapidly unfolding just across the border.

A Warm Welcome to New Perspectives

The atmosphere throughout the three-day retreat was one of warmth, camaraderie, and intellectual curiosity. Our group, though varied in disciplines, was united by a common goal: to understand how the "One Country, Two Systems" framework and the 15th Five-Year Plan translate into tangible opportunities for Hong Kong's medical community.

We were privileged to attend lectures by esteemed experts who provided a macro-level

view of the GBA's strategic importance. These sessions moved beyond abstract policy, focusing on the practicalities of healthcare collaboration within the GBA area. The discussions were lively, with colleagues from different hospitals and private practices exchanging ideas on how to harmonize our established clinical standards with the mainland's immense scale and technological momentum.

Witnessing the "Hard Power" of Innovation

A highlight of the retreat was the series of site visits to Shenzhen's technological titans: Tencent, Da-Jiang Innovations (DJI), and Mindray. For a medical professional, visiting these high-tech enterprises is eye-opening.

At Tencent, the focus on digitalization and Artificial Intelligence (AI) underscored a future where data is as vital as the stethoscope. We explored how AI-driven diagnostics and "smart" hospital management could alleviate the pressures on our own healthcare system. At DJI, the application of drone technology in emergency medicine—delivering life-saving equipment like AEDs or blood products to remote or congested areas—demonstrated how "low-altitude economy" concepts are being repurposed for public health.

Perhaps the most impressive was our visit to Mindray. Seeing high-end, domestically produced medical devices that compete on a global stage

filled us with a sense of professional pride. It also prompted a deeper reflection: there is a significant role for Hong Kong doctors to play in the clinical validation and internationalization of these technologies, acting as a bridge between national innovation and global medical standards.

From Strategy to the Stethoscope: Finding Our Role

One of the most resonant themes was the concept of "serving the country." For many of us, this phrase can feel distant from the daily reality of the consultation room or the emergency ward. However, as the retreat progressed, a clearer picture emerged.

Service is found in everyday excellence of our work and our willingness to bridge the gaps. We discussed the integration of healthcare clusters in Hong Kong—such as the recent focus on merging the Hong Kong East and West clusters—and how this mirrors the broader integration required within the GBA.

The development of national-standard "Chest Pain Centres" and "Green Channels" for emergency care provides a concrete example of how clinical pathways can be streamlined across borders. For an emergency physician or a cardiologist, these are not just administrative terms; they represent a commitment to saving lives through seamless, regional cooperation. By participating in these cross-border standards, Hong Kong doctors are not just "visiting" the mainland; we are becoming an integral part of a sophisticated, multi-tiered national health network.

The Joy of Collaborative Learning

Beyond the lectures and the high-tech tours, the true heart of the experience was the human element. The joy of the trip lay in the "classroom without walls." It was in the informal chats between a seasoned consultant and a young graduate, or the shared laughter over the impressive breakfast spread at Bauhinia Villa.

This sense of community is vital. As the boundaries of our practice expand to include the 80 million residents of the GBA, we must lean on one another. The retreat reminds us that while we are individual practitioners, we are also part of a collective medical heritage. Whether we are graduates of mainland, local or international institutions, our shared identity as Hong Kong healthcare professionals gives us a unique advantage in this new era.

An Invitation to Lead

To my fellow members of the HKCMA: the development of the GBA is not a phenomenon to be observed from distance; it is a landscape to be shaped by our expertise. Our rigorous training and commitment to evidence-based medicine are highly valued by our mainland counterparts.

I encourage you to look at the GBA not through the lens of competition, but through the lens of synergy. The three-day retreat in Shenzhen taught us that there was a vast space for professional growth, research collaboration, and clinical leadership. By engaging in these national studies and exchange programs, we gain the "cultural fluency" needed to navigate this expanded horizon.

Let us carry forward the momentum and enthusiasm of this April retreat into our daily practice. By being open-minded to the innovations and opportunities across the border, we will make unrelenting efforts to ensure that Hong Kong continues to lead, to serve, and to thrive within the national narrative.

香港醫衛界在國家「十五五」規劃中「融入和服務」 國家發展大局



許建名醫生

香港中華醫學會副會長

Dr. Christopher Kim-ming Hui

Vice-President, Hong Kong Chinese Medical Association

香港醫衛界國情班同學會 2026 年 4 月 17 日至 19 日於深圳紫荊山莊舉辦了為期三天的國情研習班。43 位醫衛界不同專業人士歡聚一堂，參加了這次精心組織和細心安排的活動。這不僅僅是一次旅行，更是有意深化「十五五」規劃核心表述「支持港澳更好融入和服務國家發展大局」的戰略行動。我有幸以香港中華醫學會副會長身份參加此次活動，獲益匪淺。

「十五五」將香港定位為「一國兩制」下積極貢獻者，發揮「超級聯繫人」和「超級增值人」作用，這標誌著從「十四五」單純「融入」向主動「服務」的演進。在醫療衛生和生物醫藥這一戰略性新興產業重點領域，「服務」具有深刻戰略內涵：香港提供高附加值、國際化專業服務，放大國家目標。具體包括融資、知識產權保護、計劃成立的香港藥物及醫療器械監督管理

中心（CMPR）的監管創新、粵港澳大灣區國際臨床試驗所的臨床試驗、「港澳藥械通」政策、人才交流及數碼健康協同。這些服務助力聯影醫療（UIH）、萬東醫療（WDM）和邁瑞醫療（Mindray）等內地企業「引進來」和「走出去」，同時推進「健康中國」和新質生產力。

研習班行程融合實地考察與專題講座，每一個環節都體現出極高的專業水準和人文關懷。第一天參觀了騰訊科技有限公司、大疆無人機展廳，並漫步深圳海上世界。紫荊山莊的夜晚，傳統的晚餐與星空下的非正式交流拉近距離。第二天參觀邁瑞醫療和崗廈北交通樞紐，隨後聆聽黃一峰老師的《一國兩制與國家安全》講座。第三天則專注課堂：王巨集德老師的《十五五規劃與香港機遇》和楊仲舒老師的《粵港澳大灣區醫療衛生協作》，最後以學員分享會結束，返回香港。



Hong Kong Medical and Health Sector's Integration and Service to National Development in Our Country's 15th Five-Year Plan

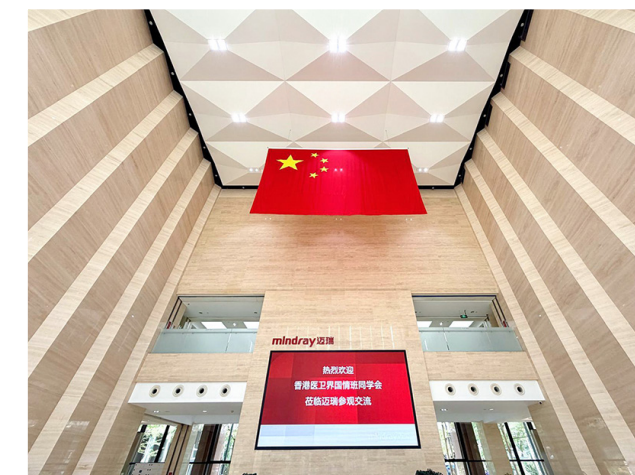
The tour's itinerary blended hands-on exploration with intellectual depth. At Tencent, participants were captivated by live demonstrations of AI-powered intelligent image analysis and WeDoctor platform capabilities. One participant shared a vivid anecdote: "Watching Tencent's big data and AI in action, I immediately envisioned integrating them into Hong Kong's systems for personalised treatment plans and remote diagnostics service. It's not just technology—it's a powerful engine for people's health and well-being."

The visit to DJI headquarters sparked creative interest. Standing before cutting-edge drones, many reflected on potential medical applications in disaster response. At Mindray, the group toured state-of-the-art production lines for imaging systems, integrated laboratory processors, ultrasound devices, and the latest in advanced patient monitors. One doctor commented that "Witnessing Mindray's breakthroughs filled us with pride. Combined with policies like cross-border ambulances and the '港澳藥械通' now covering 45 institutions and 125 devices, Hong Kong's international standards can help elevate these innovations globally, building a true 'Healthy Bay Area'."

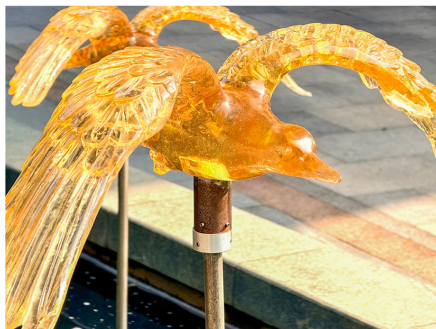
Survey results from all 43 participants underscored success. Take-home messages emphasised safety as the foundation of development and actively serving the national agenda. Reflections were rich with personal colour. An allied health professional reflected: "In the 15th Five-Year Plan's push for preventive and primary care, spine and neuro services align perfectly. Digital transformation is no longer future—it's now essential for Hong Kong

institutions entering the GBA." The group leader outlined four practical tasks as the future initiatives: internationalising mainland hospital standards via Hong Kong certification, advancing clinical trials, strengthening regulatory collaboration through "港澳藥械通", and boosting talent exchanges. Hong Kong's evolving role in the GBA, as an international innovation and clinical hub emerged clearly. By aligning rules on data flow and professional qualifications, supporting high-end clinical services, and fostering digital empowerment, participants saw themselves as vital bridges in this valuable dual-circulation strategy.

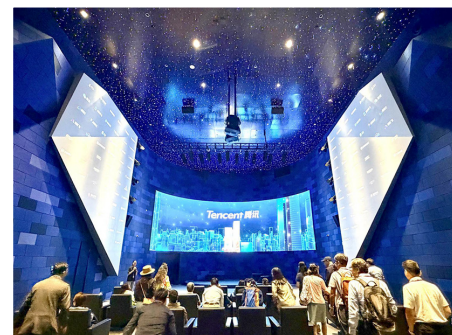
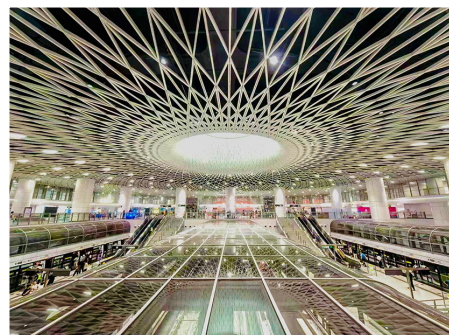
In conclusion, the 2026 tour transformed policy into lived inspiration. Participants committed to applying insights in clinic management, AI integration, cross-border projects, and talent nurturing. This mutually beneficial integration not only elevates the GBA as a world-class health bay area but also opens profound opportunities for Hong Kong's high-quality development and every professional's growth.



Hot Topics - 國情研習班



Morning coffee with Dr. Ludwig Tsoi (Group Leader).



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Hot Topics - 香港電台節目訪問

預防「三高」、擁抱健康

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香港中華醫學會理事，家庭醫學專科醫生陳曉瑞博士，應邀在香港電臺「新紫荊廣場之醫護從心出發」節目，與主持人楊子矜女士及麥尚中先生一起和聽眾分享香港的都市病 - 「三高」（高血壓、高血糖、高血脂）的防治，希望為聽眾提供實用、貼地的健康管理知識。

以下是重點內容回顧：

一、香港的「三高」現狀：

「三高」是不容忽視的都會健康挑戰，而且是「沉默的大多數」。根據衛生署的最新資料，香港其實是「三高一肥」的重災區。比如，近三成 15-84 歲香港人士患高血壓，而且超過四成患者自己並不知道，直至體檢或出現併發症才發現。約 8.5% 成年人患有糖尿病，即每 12 個人就有 1 個，而且死亡率不容忽視。超過一半的成年人膽固醇超標，是「三高」里最為普遍的一高。香港人「三高」的患病率不斷攀升，且患病趨勢年輕化。都市生活節奏快、外食文化盛行、高鹽高糖飲食隱蔽，是導致「三高」高發的主要環境因素。

二、預防「三高」的關鍵行動：從生活細節做起

1. 飲食智慧：識得揀，識得煮。

- 控鹽：警惕「隱形鹽」（豉油、蚝油、罐頭、加工食品），多用天然香料調味。
- 減糖：少飲甜飲料、凍奶茶，警惕「高升糖指數」主食（如白粥、腸粉）。代糖是從高糖飲食過渡到清淡飲食的「拐杖」，對於減肥有

輔助作用，但非萬。最終的目標是學會欣賞食物本身的味道，而不是依賴任何形式的甜味劑。

- 擇油：減少動物脂肪，多用植物油，避免反覆油炸。
- 均衡搭配：參考「三低一高」（低鹽、低糖、低油、高纖維）原則，增加蔬菜、全穀物及優質蛋白。「老火湯」里的嘌呤，脂肪和鈉含量高，對痛風，高血脂同高血壓患者尤其不適合。
- 健康小貼士：從今晚的一餐開始。「煮饀少放一勺豉油，多蒸一條魚；飲湯時撇去浮油，多食湯渣。買麵包選麥包，買飲品走甜」。



Hot Topics - 香港電台節目訪問

2. 動起來：融入生活，持之以恆

- 每周至少 150 分鐘中等強度運動（如快走、慢跑，游泳，騎車），結合抗阻訓練，減少肌肉流失。
- 減少久坐，善用碎片時間活動（如行樓梯、散步返工），每日步行 8000-10000 步，用樓梯代替電梯。
- 家庭運動小建議：一起行山、海邊慢跑、公園太極。

3. 篩查意識：「三高」是沉默的殺手，多數患者早期沒有明顯癥狀，所以要早發現，早管理。

- 定期檢測：40 歲以上建議每年檢查血壓、血糖、血脂；有家族史或肥胖者應提前篩查。
- 善用資源：45 歲以上香港人士可善用政府「慢病共治計劃」及地區康健中心服務，建立個人健康檔案。建立一個「一人一家庭醫生」的關係，是控制「三高」最有效同經濟的好辦法。



- 家庭自測：家中常備血壓計，養成定期監測習慣。

結語：健康是「儲」出來的

預防「三高」非一日之功，而是每日點滴習慣的積累。記住：「少一啖醬，多一步路；早一分鐘瞓，多一份健康儲備」。預防「三高」是一場馬拉松，讓我們一起努力，跑贏這場比賽，收穫長久的健康與活力。如有疑問，歡迎隨時諮詢你的家庭醫生！



Medical Education - CME

Diagnosis and management of resistant hypertension in primary care: a brief review and update



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Introduction

Hypertension (HT) is one of the commonest chronic diseases encountered in the community, with a prevalence of 29.5% among people aged 15 years or above in Hong Kong in 2022⁽¹⁾. It is also an important modifiable cardiovascular risk factor for the development of coronary heart disease (CHD), chronic kidney disease (CKD) and cerebrovascular accidents⁽²⁾. Therefore, all efforts should be made to achieve adequate blood pressure (BP) control among hypertensive patients to prevent its complications and to reduce its morbidity and mortality.

While most HT patients could be effectively treated by one or two antihypertensives, some may be refractory to treatment and thus called resistant HT (RH). RH is defined as failure to achieve target BP, i.e. <140/90 mmHg for overall population and <130/80 mmHg for patients with diabetes mellitus (DM) or CKD, despite treatment with optimal or maximally tolerated dose of three different antihypertensive drugs including a diuretic, or requiring four or more antihypertensive drugs⁽³⁾. In general, RH affects about 10-20% of treated HT patients⁽⁴⁾. A local study conducted in public primary care clinics in the Hospital Authority showed that the prevalence of RH was 7.4%⁽⁵⁾. RH is gaining more attentions lately as patients with RH are noted to have higher risk of cardiovascular complications such as CHD, heart failure, stroke and CKD⁽⁶⁾.

Diagnosis and evaluation of RH

Firstly, it is important to differentiate true RH from apparent or pseudo RH. The latter is usually caused by poor drug adherence, improper BP measurement techniques and the presence of white coat effect (WCE), which commonly existed in clinical practice. To confirm the diagnosis of true resistant HT, an accurate BP measurement should be ensured and the WCE should be excluded by using out of office measurement such as ambulatory BP monitoring or home BP monitoring. Furthermore, the patients' compliance to drug prescription at its maximally tolerated dose should be checked before the confirmation of a true RH.

Around 5%-25% of patients with RH have a secondary cause. Therefore, it is essential that all RH patients should be properly screened for the presence of a secondary cause. History and physical examination findings suggestive of a specific cause of secondary HT are listed in **Table 1**.



Histories and PE findings	Disorder suspected
Heavy snoring, daytime somnolence, obesity	Obstructive sleep apnea
Renal insufficiency, proteinuria	Renal parenchymal disease
Renal bruit; increase of serum Cr >50% after use of RAS inhibitor; moderate to severe HT with unilateral small kidney	Renovascular disease
Hypokalemia, increased urinary potassium excretion	Hyperaldosteronism
Central obesity, moon face, buffalo hump, abdominal striae	Cushing syndrome
Paroxysmal HT, headaches, diaphoresis, palpitations, tachycardia	Phaeochromocytoma
Arm to leg systolic BP difference >20mmHg, decreased or delayed femoral pulses, abnormal chest XR	Coarctation of aorta
Fatigue, weight gain, hair loss, muscle weakness	Hypothyroidism
Heat intolerance, weight loss, palpitation, exophthalmos, tremor	Hyperthyroidism
Headaches, fatigue, visual problems, enlarged hands, feet or tongue	Acromegaly

Table 1: History and physical examination findings and specific cause of secondary HT suspected

A common and yet often overlooked cause of secondary HT is primary aldosteronism (PA). It is the commonest cause of secondary HT, with a prevalence of ~10% among HT patients and 25% in those with RH⁽⁷⁾. Recent international recommendations advocate for systematic PA screening in all patients with HT, based on two main considerations: (i) high prevalence of PA, even in the absence of hypokalemia; (ii) increased cardiovascular risk associated with inappropriate aldosterone secretion⁽⁸⁾. PA could be screened by a plasma aldosterone/renin ratio. Renal parenchymal disease and renovascular disease are other common causes of secondary HT. Initial screening tests may include urine microscopy, serum creatinine (to calculate the eGFR), urinary protein over creatinine ratio (PCR) or urine albumin over creatinine ratio (ACR) for proteinuria

detection, +/- renal ultrasound if indicated. Another leading treatable cause of secondary HT is obstructive sleep apnea (OSA), where overnight polysomnography is required to establish the diagnosis. An apnea-hypopnea index (AHI) of ≥ 15 events/hour, or ≥ 5 events/hour in the presence of symptoms or cardiovascular comorbidities like DM, HT, IHD or stroke will confirm the diagnosis of OSA⁽⁹⁾. Other rare causes of secondary HT include endocrine diseases such as Cushing's syndrome, phaeochromocytoma, thyroid or parathyroid problems and acromegaly.

It is also important to note that some therapeutic agents may increase BP and render the patients resistant to therapy. It is therefore essential to obtain a detailed history of all concurrent prescribed or over-the-counter medications. These agents are summarized in **Table 2** according to their mechanism of action⁽¹⁰⁾.

Mechanism			
Sympathetic activation	Volume retention	Direct Vasoconstriction	Other
Cocaine	NSAIDs	VEGF inhibitors	Erythrocyte stimulating agents
Stimulants used for ADHD, narcolepsy etc	Sex hormones e.g., combined OCPs	Calcineurin inhibitors	Tyrosine kinase inhibitors
Decongestants	Corticosteroids		
Bronchodilators	Liquorice		
Antidepressants	Sodium containing antacids		

Table 2. Therapeutic agents and other substances that may affect blood pressure.

Management of resistant HT

Management of RH mainly includes intensifying a healthy lifestyle intervention, enhancing patients' adherence to drug regimen and modifying/adding new classes of antihypertensive medications. Patients should be properly counselled on sodium restriction, smoking cessation, avoiding excessive use of alcohol, body weight control, healthy sleep and having moderate intensity exercise at least 150 minutes per week. Non-adherence should always be investigated thoroughly and properly advised. Prescribing simplified regimen such as once daily medications in a fixed dose, and use of single pill combination dosing whenever possible etc. are common strategies to improve the drug compliance.

Step-by-step adjustment of the BP-lowering drugs based on the available evidence is proposed. The recommended first three drug classes for the treatment of HT are a calcium channel blocker (CCB), an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB), and a long-acting thiazide or thiazide-like diuretic. If the BP remains above goal, a mineralocorticoid receptor antagonist (MRA) such as spironolactone or eplerenone is the recommended fourth drug by most international guidelines⁽¹¹⁾. This recommendation stems from its ability to address the specific underlying pathophysiology of resistant HT, which is often characterized by volume overload, aldosterone excess, and low renin levels⁽¹²⁾ and was later confirmed by the landmark PATHWAY-2 trial which demonstrated that adding spironolactone (25-50 mg) to standard triple therapy was more effective in lowering home SBP than both doxazosin (alpha-blocker) and bisoprolol (beta-blocker)⁽¹³⁾. However, spironolactone is not suitable if patient has severe CKD (eGFR is <30 mL/min/1.73 m²) or when serum potassium levels is > 4.5 mmol/L. Caution should be taken when adding spironolactone to ACEI or ARB, as the combination may lead to serious hyperkalemia. If the patient's BP remains uncontrolled despite the use of four drugs, an agent from an additional class may be

added, including an alpha blocker, beta blocker, vasodilator such as hydralazine or central acting agent like methyldopa.

What are the novel treatments in the pipeline?

In recent years, several new drugs have been developed that may have a role in the treatment of RH. These include endothelin antagonists, aldosterone synthase inhibitors, novel non-steroidal mineralocorticoid receptor antagonist (nsMRAs), and inhibitors of angiotensinogen production by the liver with small interfering RNA (siRNA).

Endothelin antagonist

In March 2024, the FDA approved the first new and novel antihypertensive drug in 40 years, aprocitentan (Tryvio, Idorsia), a joint endothelin A and B receptor antagonist. Aprocitentan is indicated for treatment of HT in combination with other drugs in patients with RH and it was included in the new AHA/ACC guidelines as an add-on therapy for adults with RH⁽¹⁴⁾.

Aldosterone synthase inhibitors (ASI)

ASIs, such as Baxdrostat and Lorundrostat, are an emerging therapeutic class that directly suppress aldosterone production. Recent studies demonstrated that selective ASIs produce clinically meaningful reductions in office and ambulatory BP in patients with uncontrolled and RH⁽¹⁵⁾. For example, The BaxHTN trial has shown that among patients with uncontrolled or resistant HT, the addition of baxdrostat to background therapy resulted in a significantly lower seated SBP with 8.7-9.8mmHg reduction at 12 weeks than placebo⁽¹⁶⁾. Furthermore, in Bax24 trials, baxdrostat 2 mg once daily significantly reduced 24-hour ambulatory SBP versus placebo in patients with resistant HT, providing further evidence of the potential of ASI for treatment of RH⁽¹⁷⁾. Although ASIs are still not approved by FDA yet, they may represent a major breakthrough for HT management with more robust clinical trials are ongoing.

Finerenone is a ns-MRA considered as an alternative to spironolactone in cases with



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troublesome side effects. Although it was shown to inhibit fibrosis more effectively than steroidal MRAs with a better organ protective effect, it is not expected to play a major role in the management of RH because of its modest impact on BP⁽¹⁸⁾.

Small interfering RNA (siRNA) therapies, particularly zilebesiran, are emerging as a promising, novel approach for treating resistant HT. These drugs target the root cause of the renin-angiotensin-aldosterone system (RAAS) with long-acting, potentially semi-annual, subcutaneous injections, which could significantly improve treatment adherence⁽¹⁹⁾. Zilebesiran has demonstrated durable, significant BP reductions in patients with mild-to-moderate HT, with investigations ongoing for its use in more severe, resistant cases.

The role of renal denervation

Renal vascular denervation is gaining popularity in the treatment of RH. Catheter-based renal denervation (RDN) using radiofrequency or ultrasound technology is an effective, durable, and safe method for reducing both office and 24-hour ambulatory BP in patients with uncontrolled or RH for up to 3 years⁽²⁰⁾. Due to its invasive nature, RDN should be considered in selected patients whom other causes of RH are ruled out or medical therapy is ineffective, after a shared decision making on its risks and benefits.

Reference:

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Conclusion

In general, RH affects about 10-20% of treated HT patients and patients with RH are noted to have higher risk of cardiovascular complications such as CHD, heart failure, stroke and CKD. Apparent or pseudo-RH should be ruled out before the confirmation of a true RH. An accurate BP measurement should be ensured, the WCE should be excluded by using out of office measurement and patients' compliance to drug prescription should be reinforced. Around 5%-25% of patients with RH have a secondary cause, especially PA, renal parenchymal disease or OSA. All RH patients should be properly screened for the presence of a secondary cause. Management of RH mainly includes healthy lifestyle interventions and modifying/adding new classes of antihypertensive medications. Step-by-step adjustment of the antihypertensives based on the available evidence is proposed. If the BP remains above goal despite 3 different classes of antihypertensives, a MRA such as spironolactone is the recommended fourth drug. In recent years, several new drugs have been developed that may have a promising role in the treatment of RH. These include endothelin antagonists, aldosterone synthase inhibitors and catheter-based renal denervation. The management of RH should be individualized after a shared decision making on the risks and benefits of different treatment choices.



Medical Education - CME

CME Questions

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

1. Most HT patients could be effectively treated by one or two antihypertensive drug classes (T/F)
2. The prevalence of resistant HT in local primary care clinics is about 20%. (T/F)
3. Patients with resistant HT are noted to have higher risk of cardiovascular complications such as CHD, HF, stroke and CKD. (T/F)
4. Only selected patients with resistant HT should be screened for the presence of a secondary cause as it is usually uncommon. (T/F)
5. Patients' compliance to drug prescription should be checked before the confirmation of a true resistant HT. (T/F)
6. Cushing's syndrome is the commonest cause of secondary HT. (T/F)
7. The recommended first three drug classes for the treatment of RH are a CCB, an ACEI or ARB, and a beta blocker. (T/F)
8. In patient with resistant HT, if the BP remains above goal, a mineralocorticoid receptor antagonist such as spironolactone or eplerenone is the recommended fourth drug.(T/F)
9. Aldosterone synthase inhibitors (ASIs) are an emerging therapeutic class that directly suppress aldosterone production. (T/F)
10. As renal denervation is an effective, durable, and safe method for reducing BP, it should be considered in all patients whose BP is not controlled to target. (T/F)

Answer Sheet HKCMA Bulletin Issue 07 (April 2026)

Doctors are most welcome to answer the self-assessment questions to attain the CME point for respective authorities if X 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 2026 for documentation. Answers to questions will be provided in the next issue of the HKCMA Bulletin.

Diagnosis and management of resistant hypertension in primary care: a brief review and update

By Dr. Catherine Xiao-rui Chen, Specialist in Family Medicine

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

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10

Full Name (blockletters): _____ Signature: _____

HKID No. : _____ () MCHK No: _____

HKMA No: _____ or HKDU No: _____

College: _____ Fellowship No: _____

Answers to Issue 06 (January 2026)

Respiratory Syncytial Virus Infection, the Consequences and the Preventive Strategies

By Dr. Mike Yat-wah Kwan, President, Asian Society for Pediatric Infectious Diseases (ASPID)

Self-assessment Questions 1-4, 5A-E, 6: Please answer T (true) or F (false)

Q1	Q2	Q3	Q4	Q5A	Q5B	Q5C	Q5D	Q5E	Q6
F	T	T	F	T	T	F	T	T	F

Medical Education - Clinical Quiz

Cardiovascular risk and Lipoprotein(a)



Dr. Victor Yue-hong Cheng
Specialist in Cardiology
Clinical Assistant Professor (honorary),
Department of Medicine and Therapeutics,
Faculty of Medicine, CUHK

Case Study

A 43-year-old gentleman with good past health presents to the clinic for chest discomfort. He does not smoke or drink with no significant family history. Bloods including CBC, LRFT, hsTroponin, HbA1c were normal. LDL was 1.6 mmol/L. CTCA showed a moderate proximal to mid LAD stenosis (image as right side).



CC + PCI was performed (images were shown below; Left: Pre-PCI LAD image; Right: Post-PCI LAD after one DES implanted). Angiogram showed a severe proximal to mid LAD stenosis and a DES was implanted. He was started on DAPT together with atorvastatin 20 mg and ezetimibe 10 mg daily.



Medical Education - Clinical Quiz

What is Lipoprotein (a) [Lp(a)]?

Lipoprotein (a) [Lp(a)] is an independent genetic risk factor for coronary artery disease. It is a low-density lipoprotein variant which contributes to atherogenesis. Lp(a) consists of a low-density lipoprotein like particle and the specific apolipoprotein(a), which is bound covalently to the apolipoprotein(b) contained in the outer shell of the particle.

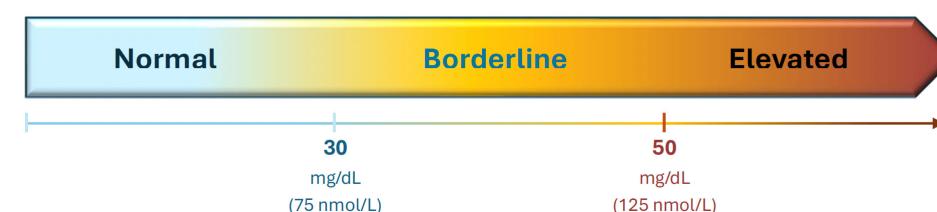
Epidemiologic and genetic studies strongly suggest a likely causal and direct continuous association between high plasma levels of Lp(a) and higher risk of atherosclerotic cardiovascular disease and aortic valve stenosis. Emerging data suggests that high Lp(a) may result in a higher risk per particle than LDL.

When should we screen for high Lp(a)?

The 2019 ESC / EAS dyslipidaemia guidelines adopted a simple recommendation that was

“Lp(a) measurement should be considered at least once in each adult person’s lifetime”. The Canadian Cardiovascular Society even added that this should be done “as a part of the initial lipid screening” of an individual. And the American College of Cardiology and American Heart Association recommend those with family history or personal history of premature atherosclerotic cardiovascular disease should also be tested.

How to interpret Lp(a) level?



- **Increased cardiovascular risk (elevated Lp(a) level):** ≥50 mg/dL (≥125 nmol/L)
- **Borderline cardiovascular risk (borderline Lp(a) level):** 30 mg/dL (75 nmol/L) to 49 mg/dL (124 nmol/L)
- **Normal Lp(a) level:** <30mg/dL (75 nmol/L)

How do we treat high Lp(a)?

Like genetics, age, gender, there is currently no direct treatment for high Lp(a). In general, we would advise more aggressive risk factor control for individuals with high Lp(a). However, there are medications that indirectly reduce Lp(a) with evidence showing that PCSK9i would reduce Lp(a) level by 23-27% in the ODYSSEY OUTCOMES and FOURIER trials. Other smaller studies have shown ineffectiveness of other lipid agents in the treatment of high Lp(a) including statins, ezetimibe and bempedoic acid. Niacin appears to decrease Lp(a) levels by 23% but its use was not recommended due to its adverse effect profile with no mortality and morbidity benefit in studies.

Currently, there are several specific medications that target Lp(a) being tested in randomised clinical trials. These injectable RNA-based therapies target apolipoprotein(a) production in the hepatocyte lower Lp(a) concentration by 80%-98%. An oral small molecule inhibitor that can lower Lp(a) significantly is also currently under development with results expected within the next one to two years.

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Medical Education - Clinical Quiz

Q1. Lipoprotein(a) [Lp(a)] is an independent genetic risk factor for atherosclerotic cardiovascular disease. Which of the following statements about Lp(a) is TRUE?

- A. Lp(a) levels are primarily influenced by dietary cholesterol intake and can be effectively lowered with statin therapy.
- B. The structure of Lp(a) is essentially identical to LDL, but with an additional apoE glycoprotein attached.
- C. High Lp(a) levels increase the risks of atherosclerosis disease and aortic valve disease.
- D. Lp(a) is recommended to be measured serially for monitoring of lipid profile as it may drastically change over time.
- E. Lp(a) concentrations remain stable throughout life and are not affected by acute inflammatory conditions.

Q2. Which of the following is accurate on lipoprotein(a) [Lp(a)] metabolism and therapeutic targeting?

- A. Lp(a) is synthesized primarily in the intestinal mucosa, and its levels can be effectively reduced with bile acid sequestrants.
- B. PCSK9 inhibitors can lower Lp(a) by 20-30%, but there are currently no available therapies specifically for Lp(a) reduction.
- C. Fibrates are the first-line therapy for elevated Lp(a) because they enhance the hepatic uptake of Lp(a) particles via PPAR- α activation.
- D. Lp(a) is only found in high levels in patients with underlying hyperlipidaemia.
- E. Elevated Lp(a) is a reversible risk factor that can be normalized with lifestyle modifications such as increased aerobic exercise and omega-3 supplementation.

Q1. Answer: C

Explanation:

- Lp(a) has a structure similar to LDL but contains an additional apolipoprotein(a) [apo(a)] linked to apoB-100. Apo(a) is highly homologous to plasminogen and competes with it, thereby reducing fibrinolysis and promoting thrombosis.
- Why other options are incorrect:
 - A: Lp(a) levels are genetically determined (mainly by the LPA gene) and are not significantly influenced by diet or lowered by statins.
 - B: The unique component is apo(a), not apoE.
 - D: Baseline Lp(a) checking is recommended in a few guidelines and is recommended to be measured at least once in the lifetime.
 - E: Lp(a) can increase during acute inflammation (e.g., surgery, infection) due to being an acute-phase reactant.

Q2. Answer: B

Explanation:

- PCSK9 inhibitors (e.g., evolocumab, alirocumab) modestly reduce Lp(a) levels, but no therapy is yet approved specifically for Lp(a) lowering. Emerging RNA-based therapies (e.g., pelacarsen, olpasiran) are in clinical trials.
- Why other options are incorrect:
 - A: Lp(a) is synthesised in the liver, not intestine, and bile acid sequestrants have minimal effect on Lp(a).
 - C: Fibrates have little to no effect on Lp(a) levels.
 - D: There is an independent and additive nature of Lp(a) and high LDL-C levels for ASCVD risk. However, there is no causal association between Lp(a) levels and LDL level as Lp(a) is mainly genetic driven while LDL-C levels are affected by diet and genetics.
 - E: Lp(a) levels are largely genetically determined and are not meaningfully lowered by exercise or dietary supplements.

Medical Education - Clinical Quiz

Dermatology Quiz



Dr. Dominic Yik-kiu Lai
Specialist in Dermatology and Venereology

Case Study

Our patient is a 70-year-old gentleman with past history of chronic hepatitis B infection, hypertension, hyperlipidaemia, impaired fasting glucose, mild renal impairment, presenting with multiple inflamed itchy lichenified eczematous plaques and nodules over his face, neck, back and limbs for more than ten years. He was diagnosed to have chronic severe eczema with suboptimal control with multiple courses of potent topical steroid or phototherapy. The relapsing condition causing sleep disturbance has a significant impact on the quality of life of our patient.



Q1. Which of the following systemic therapies should be considered in an elderly patient with multiple co-morbidities suffering from severe eczema?

- A. Methotrexate
- B. Cyclosporin
- C. Azathioprine
- D. Small molecules targeting the JAK/STAT pathway (JAK inhibitors)
- E. Monoclonal antibodies targeting the IL4/13 pathway

Q2. Which is the possible side effect of anti-IL4/13 antibodies?

- A. Injection site reaction
- B. Conjunctivitis
- C. Facial redness
- D. Psoriatic lesions
- E. All of the above

Medical Education - Clinical Quiz

Atopic dermatitis (AD) is a common chronic relapsing inflammatory skin disease affecting children, adults and the elderly population. Treatment of moderate to severe AD in the elderly population is often challenging in view of various comorbid diseases and the usage of concomitant medications. The use of conventional systemic immunosuppressive medications (e.g. methotrexate, azathioprine, cyclosporine) is frequently contra-indicated in elderly patients with comorbidities including hypertension, atherosclerotic disease, diabetes, hyperlipidaemia, osteoporosis and progressive deterioration of renal and liver functions. Moreover, elderly patients' cognitive ability, ability to self-administering medications, polypharmacy and possible drug-drug interactions are important considerations when choosing the appropriate treatment for this group of patients.¹

New targeted therapeutic options have emerged in the management of moderate to severe AD. In AD there is preferential activation of type 2 inflammatory cells, in particular Th2 cells producing interleukin (IL)-4, IL-5, IL-13 and IL-31. Monoclonal antibodies targeting the actions of IL-4 and/or IL-13 (e.g. dupilumab) and janus kinase (JAK) inhibitors targeting signal transduction and activation of transcription (STAT) (e.g. baricitinib, upadacitinib, abrocitinib) have been approved for the treatment

of moderate to severe AD. However, elderly patients or patients with multiple comorbidities are often excluded in clinical trials of systemic therapies for AD. Safety data for these special patient populations are limited. According to a scoping review of observational studies and survey of International Eczema Council members on the treatment of AD in these special populations of patients, dupilumab is the preferred first-line treatment option in patients ≥ 65 years old.² Another multi-centre retrospective observational real-life study investigating 253 patients aged ≥ 65 years affected by severe AD treated with dupilumab for 16 weeks, showed that dupilumab therapy resulted in a significant improvement of AD with a good safety profile.³ Adverse events of dupilumab therapy includes injection site reactions ophthalmic complications (e.g. dry eyes, conjunctivitis, blepharitis, keratitis, ocular pruritus), head and neck dermatitis, onset of psoriatic lesions, cutaneous T-cell lymphoma exacerbation, alopecia areata, hypereosinophilia and arthritis.⁴

Monoclonal antibodies targeting the actions of IL-4 and/or IL-13 (e.g. dupilumab) could be considered as an effective and safe treatment option for moderate to severe AD in the elderly. Ideally, clinical trial can include this special group of patients and long term drug safety data are needed.

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Past CME and Non-CME Activities

31 JANUARY 2026 (Sat)

MSD HPV Symposium

From Evidence to Action: Accelerating HPV Disease Prevention through Gender-Neutral Vaccination in Hong Kong

Speakers

Prof. Anna Giuliano
Prof. Paul Kay-sheung Chan
Guests of honour
Dr. Jane Chun-kwong Chan
Dr. Thomas Ho-fai Tsang

Panelists

Prof. Jason Ying-kuen Chan
Dr. Ann Sum-yin Chan
Moderator
Dr. Mike Yat-wah Kwan

Time: 7:30 pm – 9:15 pm
Venue: Regent Hong Kong

3 FEBRUARY 2026 (Tue)

Academic Lunch Lecture

The Burden of a Lifetime: Can Modifying Its Narrative Rewrite the Story of Atopic Dermatitis? Vaccination in Hong Kong

Speaker

Dr. Steven Loo
Specialist in Dermatology & Venereology

Moderator

Dr. Poon Man-kay

Time: 1:00 pm – 2:30 pm
Venue: The Chinese Bank's Association Ltd



Dr. Jane Chun-kwong Chan presented a souvenir to speaker, Dr Steven Loo, Specialist in Dermatology & Venereology



Dr. Jane Chun-kwong Chan presented a souvenir to the representative of the sponsor.

Past CME and Non-CME Activities

17 MARCH 2026 (Tue)**Academic Lunch Lecture**

Impact of influenza and the need for better protection against influenza

Speaker

Dr. Wong King-ying

Specialist in Respiratory Medicine

Moderator

Dr. Poon Man-kay

Time: 1:00 pm – 2:30 pm

Venue: The Chinese Bank's
Association Ltd

Dr. Jane Chun-kwong Chan presented a souvenir to speaker, Dr. Wong King Ying, Specialist in Respiratory Medicine



Dr. Jane Chun-kwong Chan presented a souvenir to the representative of the sponsor.

31 MARCH 2026 (Tue)**Academic Lunch Lecture**

Efficacy and safety of influenza vaccinations

Speaker

Dr. Daniel Wai-sing Chu

Specialist in Family Medicine

Moderator

Dr. Poon Man-kay

Time: 1:00 pm – 2:30 pm

Venue: Chariot Club



Dr. Jane Chun-kwong Chan presented a souvenir to speaker, Dr. Chu Wai Sing Daniel Specialist in Family Medicine



Dr. Jane Chun-kwong Chan presented a souvenir to the representative of the sponsor.

Past CME and Non-CME Activities

2 APRIL 2026 (Thu)**Academic Lunch Lecture**

VESALIUS-CV and the Future of Atherosclerosis Prevention: A Paradigm Shift Toward Earlier Action

Speaker

Dr. Mohamed AbdelZaherConsultant Interventional
Cardiology at King Fahd Military
Medical Complex in Dhahran,
Saudi Arabia

Moderator

Dr. Poon Man-kay

Time: 1:00 pm to 2:30 pm

Venue: Queen Victoria 8 (八公館)



Dr. Jane Chun-kwong Chan presented a souvenir to speaker, Dr. Mohamed AbdelZaher Consultant Interventional Cardiology at King Fahd Military Medical Complex in Dhahran, Saudi Arabia



Dr. Jane Chun-kwong Chan presented a souvenir to the representative of the sponsor.



Upcoming CME and Non-CME Activities

Date	Topic	Speaker/s	Time & Venue
29 April 2026 (Wednesday)	Academic Lunch Lecture Disease Modification vs. Disease Management: Dual IL-4/IL-13 Inhibition Redefining Goals in Pediatric Atopic Dermatitis	Dr. Martin Man-ho Chung Specialist in Dermatology & Venereology, Honorary Clinical Assistant Professor (HKU) Moderator: Dr. Chan Nim-tak	Time : 1:00 pm - 2:30 pm Venue : Nanhai No. 2 (南海2号)
6 May 2026 (Wednesday)	Academic Lunch Lecture Unravelling Strategies across Cardiorenal Management with SGLT2i	Dr. Michael Pak-hei Chan Specialist in Cardiology Moderator: Dr. Poon Man-kay	Time : 1:00 pm - 2:30 pm Venue : Queen Victoria 8 (八公館)
17 August 2026 (Monday)	2026 中國醫師節香港 慶祝大會	TBC	Time : 7:00 pm - 11:00 pm Venue : Hong Kong City Hall (Concert Hall)
6 September 2026 (Sunday)	2026 Annual Scientific Meeting Clinical excellence and advancement: Bridging Primary and Specialist Care	TBC	Time : 9:00 am - 6:00 pm Venue : Cordis Hong Kong Level 7 & Level 8

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2 Products are differentiated
through color



3 Strength stands
out in a colored
roundel



4 We reassure
patients with
our trusted
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6 Key info on
each side
allows pack
storage in
any direction

5 The back-of-pack
table clearly structures
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Past Social Activities

15 MARCH 2026 (Sun)

愛心捐血日

主辦機構 醫護誠信同行



香港血庫長期需要自願人士捐血補充，為此醫護誠信同行於2026年3月15日舉辦「愛心捐血日」，並獲得香港中華醫學會、香港私人執業專科醫生協會、香港西醫公會、香港牙醫學會、香港女醫生協會、香港中西醫結合醫學會、香港大學李嘉誠醫學院護理學院、香港護理學院、香港藥學會、香港醫藥經銷業協會聯合協辦。大家齊心團結，真是令人鼓舞！

活動獲行政會議成員，前食衛局長高永文醫生、林哲玄議員、中聯辦協調部胡文華、潘健春先生、香港中華醫學會王敏菁醫生、香港私人執業專科醫生協會吳少君醫生、香港西醫公會雷浩然醫生、香港牙醫學會周明忠、李鈺雯牙醫、香港中西醫結合醫學會余秋良會長、趙志輝醫生、香港大學李嘉誠醫學院護理學院李惠慈教授、香港護理學院顧慧賢會長、香港藥學會沈明達會長、香港醫藥經銷業協會韓儒俊先生到場支持。由於

血液無法替代且保存期限有限，每日均有患者急需輸血，補充血庫存量刻不容緩。

本次活動共吸引超過40人登記捐血。醫護誠信同行主席王予婷醫師表示，捐血救人意義重大，該組織至今已成功举办8次大型獻血活動，未來將繼續推動這項傳統，鼓勵市民積極參與，共同為香港血庫助力。本次現場工作的志願者有：王予婷醫生、林子雲醫生、李詩悅醫生、陳德仁醫生、林潔瑩醫生及陳煒文護士等。

王醫生特別提醒：香港紅十字會輸血服務中心已自2022年12月21日起，解除曾於英國、法國或愛爾蘭居住人士因「瘋牛症」風險而暫緩捐血的規定，相關人士現可重新捐血。

捐血是跨越背景的生命禮贈。醫護團體已帶頭行動，呼籲所有符合資格的市民踴躍參與，以熱血守護生命，真正做到以愛為橋，以血為紐，攜手共築全城生命防線！

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
慢性腎病免費篩查
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
請立即向醫生查詢

HONG KONG CHINESE MEDICAL ASSOCIATION LTD.
香港中華醫學會



HONG KONG CHINESE MEDICAL ASSOCIATION LTD.

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