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The Cover Shot



Skiing is a thrilling winter sport that involves gliding down snowy slopes on skis. It combines elements of athleticism, adventure and enjoyment in a breathtaking outdoor setting. While progressing on the skill level, skiing requires our bodies to act against our instinct for balance.

Weight reduction also involves doing things against our instincts - to cut calorie intake against our hunger sensation.

Obesity management, therefore, requires multidisciplinary team management to help our bodies become accustomed to new lifestyles. Professional support is essential in achieving long term weight targets.



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Editorial

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Issue Editor



Dr TSUI Tsun-miu

Obesity is a chronic, progressive and relapsing disease. A body mass index of 25 kgm⁻² or above is defined as obesity in the Asian population. According to the Population Health Survey (PHS) 2020 - 22 conducted by the Department of Health of the Government of the Hong Kong Special Administrative Region, 32.6 % (26.4 % of females and 39.4 % of males) of persons aged 15 - 84 had a BMI \geq 25.0 kgm⁻². Despite the high prevalence of the disease, obesity is not commonly known as a disease among the public. In general, people are willing to seek medical advice for high blood pressure, high blood sugar or high cholesterol but not for high BMI. People usually start to seek medical treatment when they develop obesity related co-morbidities (e.g. type 2 diabetes, hypertension, dyslipidemia, obstructive sleep apnea, coronary artery disease, heart failure, atrial fibrillation, asthma, fatty liver disease and nonalcoholic steatohepatitis, chronic kidney disease, polycystic ovarian syndrome, infertility, gastroesophageal reflux disease, pseudotumor cerebri, and bone and joint diseases).

When managing obesity related co-morbidity, successful weight management usually helps ameliorate the co-morbidity. This relationship is often observed in treating diabetes and hypertension. Successful weight management improves diabetes and blood pressure control. In this issue, respiratory physicians Dr Kwok Wang Chun and Dr Terence Chi Chun Tam are going to share with us the similar relationship that happens between obesity and asthma.

Childhood obesity has become more prevalent worldwide over the past few decades. Changes in diet, increased consumption of unhealthy foods, reduced physical activity, and sedentary behaviours have been identified as some of the contributing factors. To manage childhood obesity, pharmacotherapy also plays an important role. Dr Queenie WS See, a paediatric endocrinologist, has provided an overview of the pharmacotherapy management of obesity in children.

A healthy lifestyle is always the cornerstone for successful long term weight management. To change a person's lifestyle and behaviour is always challenging. Dietitian is one of the key members of a weight management team. Dietitians assist people with obesity to adopt new lifestyles to promote weight reduction. However, traditional face-to-face consultation is difficult for Hong Kong people because of their busy work life. Ms Sylvia See Way Lam, a registered dietitian, is going to share an online workplace weight management program in Hong Kong with us. Dietitian intervention is more diversified and no longer limited to consultation room counselling.

Bariatric surgery is often regarded as the "last resort" treatment for obesity. This is, however, not an accurate description. To decide which obesity treatment regime to offer, we need to consider a number of factors, including a person's BMI level, general health condition, obesity co-morbidity status, educational and social background, and most importantly, one's own wish. Bariatric surgery could be offered as treatment following lifestyle modification when the patient's condition fulfils the criteria for bariatric surgery. Dr Chan Man Pan, a general surgeon as well as the president-elect of the Hong Kong Obesity Society, will tell us about the updated surgical treatment of adult diabetes and the updated criteria for bariatric surgery candidates.

Last but not least, Dr Tellus Man Yuk Ng, the president of Hong Kong Obesity, will share with us her trip to Madagascar. To fight obesity, we need to properly address obesity as a disease. People living with obesity are commonly blamed due to misconceptions and biases. Weight stigma leads to incorrect assumptions that obesity is only a person's individual responsibility. The multidisciplinary team approach is often needed to change one's lifestyle and to achieve successful and durable weight management results. We can all work together to ensure happier, healthier, and longer lives for everybody.



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A Report on a Corporate-Sponsored Online Workplace Weight Management Programme - Something Worth Investing in for Staff Wellness

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Ms Sylvia See-way LAM

INTRODUCTION

It has been well established that obesity is related to an increased risk of many chronic diseases, including diabetes, heart disease, cancer, neurovegetative diseases, and more. Not only does obesity affect individual health, but obesity is also considered an occupation hazard that can compromise productivity, worsen mobility and morale, and increase healthcare claims, sick days, and occupational injuries^{1,2}. Well-structured workplace wellness programmes that include components in weight management, increased physical activity, smoking cessation, stress management, regular health screening for staff, etc., were shown to help decrease direct health care costs, improve healthcare utilisation, increase work performance, lower rates of absenteeism, and a reduced prevalence of chronic disease³.

In 2009, the Centers for Disease Control and Prevention (USA) estimated that a 10 % weight loss would reduce an overweight individual's lifetime medical costs by USD 2,200 to USD 5,300 by lowering costs associated with the treatment of hypertension, type 2 diabetes, heart disease, stroke, and high cholesterol^{3,4}. A 2017 study by the Johns Hopkins Bloomberg School of Public Health showed that helping a 40-year-old adult go from being obese to overweight can save an average of USD 18,262. If the same person went from being obese to normal weight, it could result in an average savings of USD 31,447⁵.

In Hong Kong, the obesity rate has been gradually increasing over the years. The Population Health Survey 2020 - 22 conducted by the Department of Health showed that 32.6 % of local persons aged 15 - 84 were obese, and another 22.0 % were overweight; 37.8 % and 35.4 % were classified as centrally obese when defined by waist circumference and waist-to-hip ratio respectively⁶. Even though there is a lack of studies on the reduction of obesity concerning the health cost of Hong Kong people, with a prominent Hong Kong population participating in the workforce, implementing a well-structured and effective weight management programme for overweight staff should anticipate benefits to corporate company's productivity, and most importantly to reducing healthcare cost through improvement of staff health.

Traditionally, most corporate wellness programmes, including weight management programmes, were delivered physically. However, after the COVID-19 pandemic, virtual meeting platforms (e.g., Zoom,

Microsoft Teams, Google Meet, etc.) became popular as a telemedicinal tool. The use of telemedicinal tools to deliver corporate wellness programmes may help reduce travelling expenses, improve accessibility, facilitate better communication between individuals and groups, save time, and increase staff participation rate⁷. Besides virtual meeting platforms, WhatsApp®, a commonly used instant messaging tool, may facilitate interactive support, resulting in a more successful weight loss^{8,9}.

In order to demonstrate that virtual care is worth investing in and implementing by large corporations to increase productivity in a Hong Kong setting, the effectiveness of virtual care on weight loss among overweight participants in an online corporate-sponsored weight management programme is herein described.

METHODOLOGY

A dietitian was invited by the Human Resources Department of a leading health insurance company in Asia to design and implement an online weight management programme for their staff in Hong Kong in Q1 of 2023. The dietitian tailored an online weight management programme for the corporation that lasted 13 weeks, consisting of four 30-minute individual sessions (weeks 0, 2, 7, 10) and two 1-hour peer support group sessions (weeks 4 and 13). Each peer support group session gave a 30-minute nutrition education presentation (Healthy Eating Out Skills at week four and Long-term Weight Management Skills at week 13) and peer discussion in the remaining session.

An internal recruitment email with a programme screening questionnaire (Appendix I) was sent to all office staff located in Hong Kong two months before the start of the programme. Enrollment in this programme was given priority to those who were most overweight based on their self-reported body weight, height, and body mass index. Priority also increases if metabolic syndromes are reported. The corporations covered all costs as staff benefits. Based on the screening questionnaire, two groups of eight participants were recruited. The programme was launched in Q3 of 2023.

Participants were asked to send a 3-day food diary to the dietitian before the start of the programme. On the first online individual consultation, a 7-day meal plan ranging from 1,200 to 2,000 kcal a day (45 - 55 % carbohydrates: 20 - 25 % protein: 20 - 35 % fat) was provided based on their reported food intake for the



Appendix I: Programme Screening Questionnaire (Developed by author)

Name:	Last Name:	First Name:
D.O.B:	DD/MM/YY	
Gender:	M / F	
Current Weight:	_____ KG	
Height:	_____ cm	
BMI:	_____ kg/m ²	
Body Fat%	_____ % or don't know	

Do you have any of the following health conditions?

☐ Diabetes
☐ High blood cholesterol
☐ High blood pressure
☐ Fatty Liver
☐ Gout
☐ Joint pain
☐ Anemia
☐ Osteopenia/osteoporosis
☐ Eating Disorders (e.g., Anorexia/Bulimia/Binge Eating Disorder)
☐ Psychiatric Disorders (e.g., anxiety disorder, depression)
☐ Food allergy/intolerance: Pls specify what type(s): _____
☐ Others: Please specify: _____

Are you currently on any medications/nutritional supplements?

☐ No
☐ Yes. Please specify: _____

What are your nutritional targets? (You can choose one or more choices):

☐ Improve overall health
☐ Weight Loss. What is your target weight? _____ kg
☐ Control body fat %
☐ Muscle gain
☐ Improve blood sugar level
☐ Improve blood cholesterol level
☐ Improve blood pressure
☐ Improve mental wellness
☐ Others: Please specify: _____

Have you tried any of the following special diet(s) before?

☐ No, I haven't tried any of the following diets
☐ If yes, please choose the one(s) that you have tried
☐ Low fat diet
☐ Low carbohydrates diet
☐ Low calorie diet (<1,200 kcal a day)
☐ High protein diet
☐ Ketogenic diet
☐ Gluten-free diet
☐ Vegetarian diet
☐ Meal replacement diet
☐ Others: Please specify: _____

How much exercise do you do weekly?

☐ < 30 minutes
☐ 30 to 90 minutes
☐ 90 to 150 minutes
☐ > 150 minutes

What type(s) of exercise do you do? _____

Do you have any specific nutritional concerns?

☐ No
☐ If yes, please specify: _____

participants to follow. All participants were advised to drink at least 2 litres of water daily. They were granted a 3-month fitness centre membership in their office and encouraged to walk at least 5,000 to 8,000 steps daily, facilitating the physical activity. The dietitian informed all participants to achieve a 5 to 10 % weight loss by the end of the programme. A WhatsApp® group chat was set up for each group to monitor and support them closely over the 13 weeks. They were instructed to send food pictures and physical activity recorded daily to the chat group, ensuring compliance. They were also asked to send their weekly weight and body fat percentage records privately to the dietitian via WhatsApp®, using the BIA scale available in the office fitness centre for accuracy.

Incentives (e.g., supermarket coupons and club points) were given at week five if participants could lose 3 % of their baseline weight and at the end of the programme if they reached a 7 - 10 % weight loss to increase participants' motivation and compliance. Participants who attended all sessions were also rewarded for increasing the participation rate.

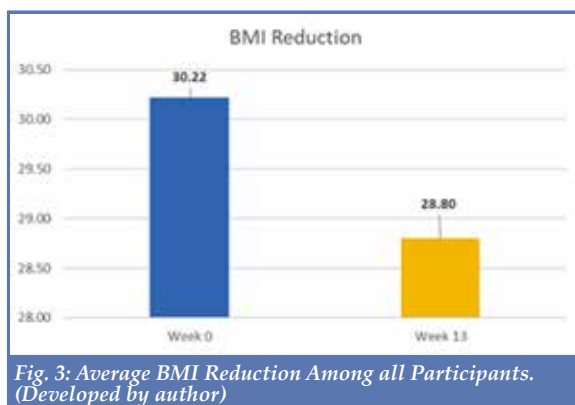
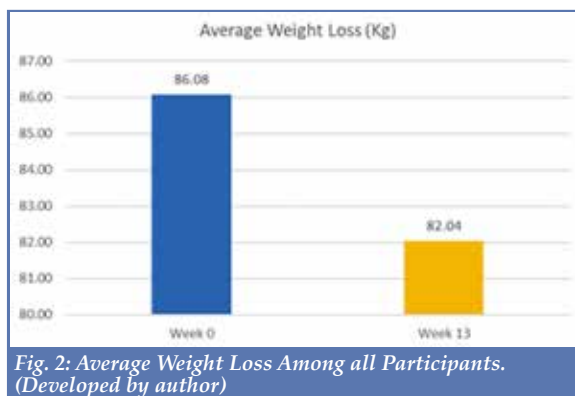
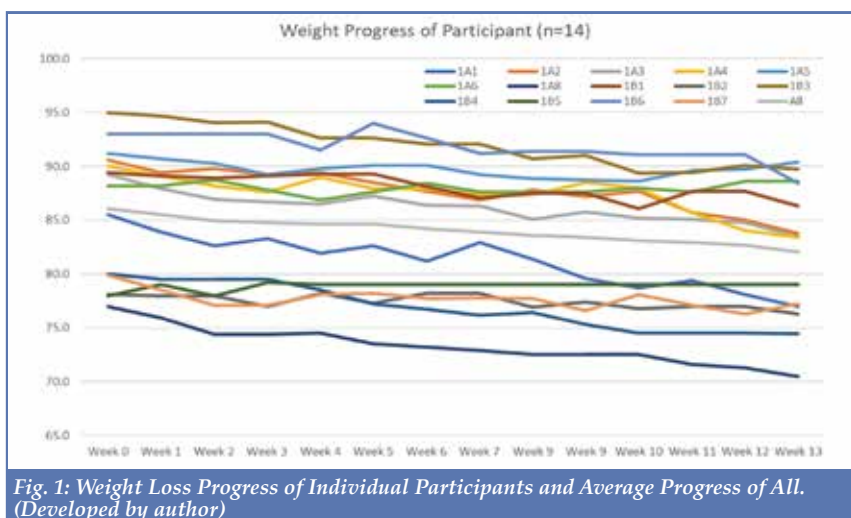
RESULTS

Sixteen participants were recruited (10 males and 6 females), and 2 males were excluded due to a participation rate of less than 30 % (n = 14). The average baseline weight was 87.1 ± 5.9 kg, the average height was 169 ± 0.07 cm, and the average baseline BMI was 30.2 ± 2.2 kg/m² (i.e., morbidly obese). The average weight and BMI at week 13 were 82 ± 6.09 kg and 28.8 ± 2.22 kg/m² (i.e., obese), respectively, resulting in an average of 4.0 ± 2.8 kg weight reduction (-4.69 ± 0.04 %) and a BMI reduction of 1.4 ± 1.0 kg/m² in 13 weeks. Individual and average weight loss progress is shown in Fig. 1. Unfortunately, body fat percentage was not accurately measured for all participants due to misuse of the scale, use of different BIA machines by individual participants, and limited access to the office fitness centre due to travelling time and distance between offices.

DISCUSSION

It has been well-published that people with obesity who reduced their weight by 5 % had improvements in metabolic functions (e.g. diabetes risk and improved glycemic control, blood pressure and lipid profile), while further weight loss of 10 to 15 % resulted in some additional improvements (e.g. obstructive sleep apnoea, non-alcoholic fatty liver). Most treatment guidelines recommend that people who are overweight or obese aim to lose 5 % to 10 % of their weight to achieve improvements in health¹⁰. In addition, moderate weight loss (5 - 10 %) has been shown to be associated with reduced healthcare costs^{10, 11}.

This 13-week corporate-sponsored online workplace weight management programme online weight management programme resulting in an average of -4.0 ± 2.8 kg weight reduction (-4.69 ± 0.04 %). The BMI dropped from the classification of morbidly obese to obese by a reduction of -1.4 ± 1.0 kg/m² in 13 weeks. (Fig. 2 and 3).



The best-performed participant achieved a maximum weight loss of 8.5 kg (11 %), while the poorest-performed participant gained 1.0 kg (+ 1 %). More significant successful weight loss occurred in the participants who regularly reported their food and exercise record in the WhatsApp® chat group, weekly weight reporting, active online interactions between participants and the dietitian, and increased physical activity by daily walking and/or frequent visits to the fitness centres or regular exercise classes. Reminding the participants that incentives would be granted when reaching particular milestones could be one of the stimuli for better weight reduction.

There are some limitations to this programme. One of the limitations was the operation and accessibility of the BIA scale. Some participants misused the scale, while some could not visit the office fitness centre regularly to take the measurements. As the BIA scale was a home-use model, it might not be as accurate as the one used in medical clinics, resulting in imprecise body fat percentage and lean muscle mass measurements, which could be important health improvement indicators resulting from weight loss. In addition, to evaluate whether weight loss helped improve metabolic functions, the corporation could have sponsored participants a basic health assessment, including blood tests and blood pressure measurements before and after the programme. Staffing was also a limitation as only one dietitian carried out the entire programme, from design, scheduling, administration, and implementation to reporting. Limited staffing restricted the number of enrollments and reduced the programme's cost-effectiveness. Some participants suggested that a few face-to-face meetings with the dietitian in the programme might also be helpful in motivating weight loss. Involving a professional physical trainer or physiotherapist in the programme, either online or face-to-face, might assist participants in performing physical activity more regularly and correctly. Lastly, the increased duration of the programme (optimally 16 to 24 weeks) and more intense individual or peer support group sessions could also make this programme more successful in weight loss and maintenance¹². However, all these programme improvements might require the corporation to raise its budget to invest in corporate wellness programmes, which could be one of the most considerable constraints.

CONCLUSION

The study showed that a well-structured corporate-sponsored online weight management programme resulted in successful weight loss for staff. Key factors for success include identifying suitable candidates (i.e., high BMI with metabolic conditions), providing clear and feasible weight loss targets (i.e., 5 - 10 % weight loss), regular reporting of weight, food, and exercise records of active interactions between the participants and health professionals (e.g., dietitians, physical trainers, doctors)



through instant messaging apps, increased physical activity by providing environmental support (e.g., sponsored fitness centre membership, sports devices to track steps), and incentives to achieve certain milestones during the programme.

Well-structured workplace wellness programmes that include components in weight management, increased physical activity, smoking cessation, stress management, and regular health screening for staff were shown to help decrease direct healthcare costs, improve healthcare utilisation, increase work performance, lower rates of absenteeism, and a reduced prevalence of chronic disease³. This study further confirmed that large corporations in Hong Kong should intensify their human resources budget for a cost-effective online workplace weight management programme to benefit staff wellness.

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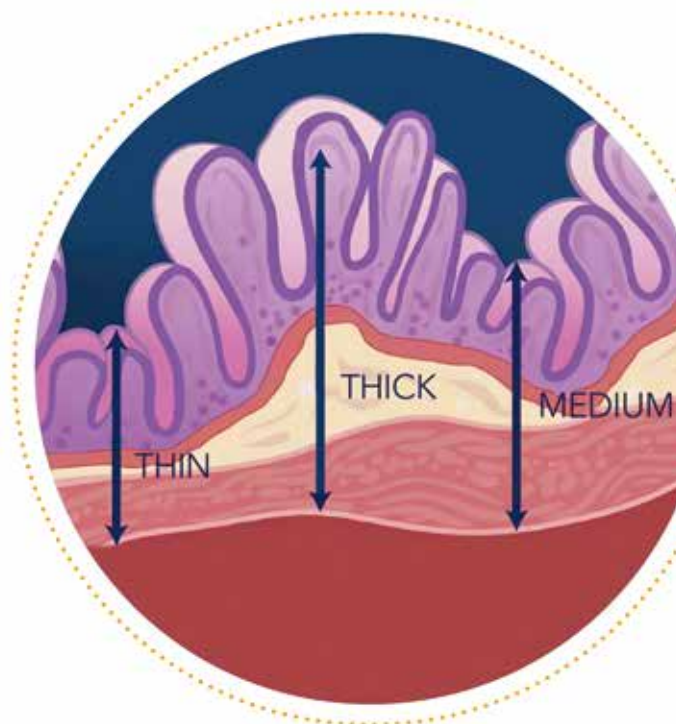
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Pharmacotherapy Management of Obesity in Children

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INTRODUCTION

Obesity is a common, chronic, and complex disease that is associated with serious health and mental consequences if not treated¹. It is a complex interplay of genetic, physiological, socio-economic, and environmental factors. In the World Obesity Federation's World Obesity Atlas 2023², it expects that 25 % to be obese by 2035, and the rate of childhood obesity will more than double from 2020. Over the past decades, intensive lifestyle modification has been the focus in treating obesity in children and adolescents. Yet, there are a lot of constraints for it to be effective. Together with the lockdown measures such as school and sports facilities closure during the Covid pandemic, the situation of childhood obesity worsened. In view of the rapid rise in the rate of childhood obesity and the refractory nature of obesity, the American Academy of Pediatrics has issued a Clinical Practice Guideline for the evaluation and treatment of children and adolescents with obesity³. It is the very first clinical guideline to address the specific treatment of childhood obesity, aiming to tackle childhood obesity aggressively. One of the revolutionary moves includes the recommendations for anti-obesity medication in children with obesity as an adjunct to intensive lifestyle modification. The four FDA-approved anti-obesity medications for children ages 12 and above with obesity (BMI \geq 95th percentile) are as follows:

ORLISTAT

Orlistat is a lipase inhibitor. Taking it orally with a meal containing fat (at a dose of 60 - 120 mg 3 times per day), it prevents fat in the food from being absorbed in the intestine through inhibition of pancreatic and gastric lipase. However, the unabsorbed fat will be removed from the body in stool, causing steatorrhea, faecal urgency, and flatulence; these adverse effects greatly limit its tolerability. It also decreases fat-soluble vitamin E and D absorption. It is contraindicated in chronic malabsorption and cholestasis. In a recent meta-analysis⁴, Orlistat had a beneficial effect on waist circumference and insulin levels in children and adolescents. However, the effects of Orlistat on weight, BMI, blood glucose level, and lipid profile, while beneficial, were insignificant.

QSYMIA

It is a combination of phentermine and topiramate in an extended-release capsule. Phentermine is

a sympathomimetic that suppresses appetite. Phentermine alone is approved for obesity management in adolescents aged \geq 16 years old. Topiramate is an anti-epileptic drug. It can be used to prevent migraine. When used with phentermine, it augments the effect of phentermine. Study⁵ shows that the BMI percent change was -10.44 (high dose; 15 mg/ 92 mg) and -8.11 (mid dose; 7.5 mg / 46 mg) at 56 weeks compared with placebo. It also improved HDL and TG cholesterol profiles.

GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)

There are 2 approved GLP-1 RAs for children ages 12 and above with obesity: Liraglutide and Semaglutide. They work by reducing hunger via slowing down gastric emptying and suppressing appetite in the brain.

LIRAGLUTIDE [SAXENDA]

Saxenda (daily injection) was found more effective than placebo in weight loss at one year among patients 12 years and older with obesity in a randomised control trial⁶. The weight lost was approximately 4.5 kg for absolute change and the BMI reduction was also greater in the liraglutide group with a -4.64 percentage point reduction⁶. The recommended starting dose is 0.6 mg per day with an increment on 0.6 mg weekly till reach a maximum dose of 3.0 mg per day, by subcutaneous injection⁷.

SEMAGLUTIDE (WEGOVY)

Wegovy (weekly injection) was recently approved by FDA in December 2022 for use in paediatric patients \geq 12 years old with obesity. It is a weekly subcutaneous injection at a dose of 2.4 mg. In the STEP TEENS clinical trial⁷, results showed 16.1 % BMI reduction compared to 0.6 % BMI increase in the placebo group after 68 weeks of use⁷. It is recommended to start at a dose of 0.25 mg once weekly via subcutaneous route and gradually increase the dose every 4 weeks till it reaches either 1.7 mg or 2.4 mg maintenance doses as recommended by the healthcare professionals⁹.

Both Saxenda and Wegovy have the adverse effects of gastrointestinal upset, including nausea and vomiting. They are contraindicated in patients with a personal or a family history of medullary thyroid cancer or multiple endocrine neoplasia syndrome type 2 (MEN2).



CONCLUSION

The recent 2023 AAP guideline has changed the previous treatment paradigm from mainly intensive lifestyle modification in childhood obesity to early initiation of pharmacotherapy treatment as an adjunct to lifestyle modification. The use of pharmacotherapy treatment demonstrates more clinically significant improvement in BMI, bringing hope to the children with obesity. However, the new anti-obesity medications are expensive and not always affordable for the families. In order to help our future generation, it is important for our policy makers and the community need to work together to aim at healthy lifestyle and obesity prevention.


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Dermatology Quiz



Dermatology Quiz

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Fig.1: Linear band along the full length of the right leg



Fig.2: Close-up of the lesion

This 14-year-old boy had developed this asymptomatic hypopigmented linear band along his right leg (Fig. 1 & 2) for six months. His mother recalled that the lesions appeared suddenly with some redness and fine scaling in the first few months. Apart from this, he had no lesions elsewhere. In the past history, he had atopic dermatitis, which was in remission. There was no significant family history.

Questions

- What are your clinical diagnoses and differential diagnoses?
- How would you establish the diagnosis?
- How do you treat this patient?
- What is the prognosis of this disease?

(See P.32 for answers)

Obesity-associated Asthma - A Distinct Phenotype

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INTRODUCTION

Phenotyping in airway diseases, such as asthma, has gained significant attention due to its potential for personalised treatment using simple and readily available tests. Within the spectrum of asthma phenotypes, obesity-associated asthma stands out with its distinct clinical features and treatment implications. This article will delve into the clinical features specific to this asthma phenotype.

BIDIRECTIONAL RELATIONSHIP BETWEEN ASTHMA & OBESITY

Asthma is a heterogeneous airway disease characterised by chronic airway inflammation resulting in respiratory symptoms, such as shortness of breath, cough and wheezing¹. It encompasses a diverse array of phenotypes driven by various endotypes². Among these phenotypes, the most prevalent are those driven by T2 inflammatory profile (T2-high asthma)³. By contrast, obese asthmatic patients predominantly exhibit a non-eosinophilic (T2-low) phenotype, and a unique sub-phenotype known as "obesity-associated asthma" has been proposed⁴⁻⁶. The relationship between obesity and asthma is influenced by a complex interplay between biological, physiological, and environmental factors⁷. The low grade inflammatory state is characterised by a state of low-grade systemic inflammation marked by the activation of M1 macrophages and CD8+ T cells and an increase in inflammatory indicators such as Toll-like receptor 4 (TLR4), interleukin (IL)-1b, IL-6 and IL-17, interferon (IFN)- γ , tumour necrosis factor (TNF)- α , leptin, and resistin⁸⁻¹⁰.

The relationship between obesity and asthma is complex and bidirectional. First, obesity is linked to an increased incidence of asthma, with evidence suggesting a dose-dependent relationship⁵, as well as a higher risk of severe asthma and asthma-related hospitalisations⁴⁻⁶. The underlying mechanisms are likely multifactorial including genetic susceptibility, environmental factors (e.g., in utero, physical activity, diet), mechanical effects, as well as the induction of both local and systemic inflammatory states common in obesity. Larsson and Burgess et al. conducted a study involving over 200,000 individuals from Mendelian randomisation studies and de novo analyses of the FinnGenn consortium, which established a causal relationship between higher BMI and increased risk of several chronic diseases, including asthma¹¹. Similar genetic patterns were also observed in another study

involving African American patients with obesity and asthma¹². Additionally, a genetic linkage analysis among Costa Rican family members revealed that PRKCA, a pleiotropic genetic locus, was associated with both higher BMI and asthma within the population¹³. In a separate Japanese cohort with 8,000 individuals, being overweight or obese and having a higher waist circumference were identified as significant risk factors for the development of incident late-onset asthma, particularly in middle-aged women¹⁴.

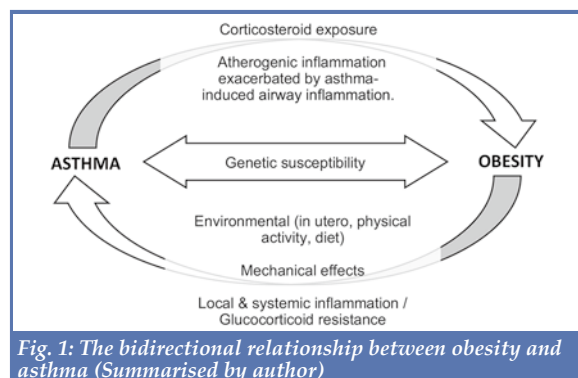
At the same time, studies also indicated that individuals with asthma face an increased risk for developing obesity. This increased could be attributed to factors such as corticosteroid exposure from asthma treatment, atherogenic inflammation exacerbated by asthma-induced airway inflammation, or common upstream factors affecting asthma and weight. In a cohort of 2,171 non-obese children from the Southern California Children's Health Study, it was found that those with asthma had a 51 % higher risk of developing obesity over 10 years compared to those without asthma¹⁵. Similarly, a 8,713 children-strong multi-cohort study by Stratakis et al. revealed that individuals with asthma had a 23 % higher risk of developing obesity¹⁶. Additionally, a large-scale European multi-cohort study with more than 500,000 subjects reported that adult-onset or late-onset asthma patients had higher risks of being overweight/obese¹⁷.

In terms of clinical features, obesity is linked to a higher frequency and severity of exacerbations of asthma. To et al. found that in female patients with adult-onset asthma, a body mass index $> 25 \text{ kg/m}^2$ was associated with a significantly increased likelihood of frequent exacerbations, with an adjusted odds ratio of 2.29¹⁸. Furthermore, obesity impacts the severity of asthma exacerbations; individuals with asthma who are obese have a higher risk of mechanical ventilation use and experience a longer length of hospitalisation¹⁹. Patients with obesity-associated asthma also exhibit increased resistance to corticosteroids, which is the cornerstone of anti-inflammatory controller therapy in asthma. Studies showed that individuals with obesity require a higher dose of inhaled corticosteroid (ICS) to achieve sufficient asthma control. Two Japanese studies both demonstrated that asthma patients with obesity were treated by high-dose ICS more frequently but still had increased exacerbations and decreased pulmonary function compared to those without obesity^{20, 21}. A potential explanation may lie in the downregulation of a glucocorticoid-responsive gene, known as mitogen-activated protein kinase phosphatase-1 (MKP-1), in



peripheral blood mononuclear cells and bronchoalveolar lavage fluid in patients with obesity and asthma.²²

The bidirectional relationship between obesity and asthma is visually summarised in Fig. 1, providing a simplified overview of the complex interplay between these two conditions.



MANAGEMENT OF OBESITY-ASSOCIATED ASTHMA

Currently, no approved treatment specifically treats obesity-associated asthma. However, weight reduction interventions, such as diet restriction, exercise and bariatric surgery when appropriate, have been shown to improve asthma severity in patients with obesity²³⁻²⁵. Another area of interest is the potential use of microbiome-targeted therapies, such as faecal microbial transplantation, prebiotics and probiotics, since the gut microbiome has been observed to be disturbed in this asthma phenotype²⁶.

Macrolide is a more readily available option which may be useful for obesity-associated asthma. The AMAZES study demonstrated that azithromycin significantly reduces the risk of asthma exacerbations irrespective of the blood eosinophil level²⁷. Glucagon-like peptide one receptor (GLP1R) agonists, which improve insulin sensitivity and increase nitric oxide (NO) bioavailability through inhibition of ADMA, have shown observational association with improved asthma outcomes²⁸. The presence of GLP1 receptor in lung epithelial and endothelial cells may explain its potential benefits²⁹. Preclinical murine models³⁰ and ex vivo studies²⁹ also demonstrated that the administration of GLP1R agonists significantly inhibits allergic and viral airway inflammation, decreasing airway eosinophilia, mucus production, and hyperresponsiveness^{31,32}.

CONCLUSION

Obesity-associated asthma is a well reported phenotype with distinct clinical features with an increased likelihood of glucocorticoid resistance. Although there are currently no FDA-approved medications that are specifically indicated for obesity-associated asthma, certain existing medications, such as macrolide and GLP1-R agonists, might provide clinical benefits. Lastly, the importance of weight reduction cannot be overstated.

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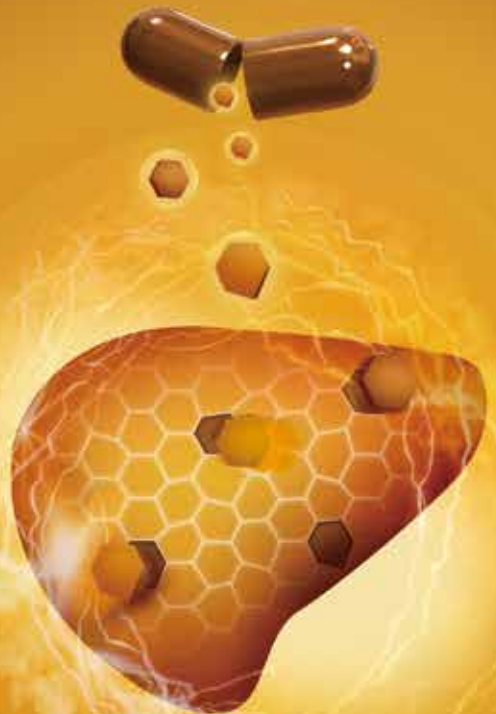
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For Healthcare Professionals Only

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Surgical Treatment of Adult Diabetes

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This article has been selected by the Editorial Board of the Hong Kong Medical Diary for participants in the CME programme of the Medical Council of Hong Kong (MCHK) to complete the following self-assessment questions in order to be awarded 1 CME credit under the programme upon returning the completed answer sheet to the Federation Secretariat on or before 31 March 2024.

INTRODUCTION

Diabetes refers to the coexistence of obesity and type 2 diabetes mellitus (T2DM). There is a strong pathophysiological link between these two, as obesity is associated with insulin resistance and pancreatic β -cell dysfunction¹. The global prevalence of obesity has tripled since 1975², and a similar trend has been observed in T2DM³. In 2020, 813 million adults were obese, defined by Body Mass Index (BMI) ≥ 30 kg/m², and this number is estimated to reach 1.5 billion by 2035⁴. In 2021, there were 500 million adults living with diabetes globally^{5, 6}, and T2DM made up 96 % of all cases⁵. It is projected that by 2050, more than 1.3 billion people will have diabetes.

High BMI was shown to be the primary risk factor for T2DM and contributed to 52.2 % of disability-adjusted life-years worldwide⁵. In 2021, diabetes is responsible for 6.7 million global deaths and at least 966 billion US dollars in health expenditure⁶. The link between obesity and T2DM is bidirectional. Obesity increases the risk of developing T2DM, and T2DM worsens the metabolic dysfunctions associated with obesity, leading to further weight gain. Combined metabolic dysfunction of obesity and T2DM increases mortality and morbidity of cardiovascular disease, metabolic-associated fatty liver disease (MAFLD), obstructive sleep apnoea, osteoarthritis and cancers. Diabetes is no doubt an immense global challenge to healthcare in the coming decades. A multi-disciplinary approach is vital, and Metabolic and Bariatric Surgery (MBS) plays a key role in the armamentarium.

COMMON MBS PROCEDURES FOR DIABESITY AND MECHANISM OF ACTION

Currently, the most common MBS procedures performed globally are Sleeve Gastrectomy (SG, Fig. 1), followed by Roux-en-Y Gastric Bypass (RYGB, Fig. 2). These two procedures take up 90 % of all MBS procedures⁷. Sleeve Gastrectomy refers to removing most parts of the greater curve and the whole of the fundus, resulting in a tubular stomach. Sleeve Gastrectomy is technically easier to perform than RYGB, and no anastomosis is required. Roux-en-Y Gastric Bypass involves the construction of a small proximal

gastric pouch (20 - 30 mL), which is separated from the rest of the stomach. Two limbs of the small intestine (roux limb/alimentary limb and biliopancreatic limb) are obtained by dividing the jejunum at a predesigned length distal to the ligament of Treitz. The alimentary limb is anastomosed to the small gastric pouch, and the biliopancreatic limb is anastomosed to the alimentary limb. The length of alimentary limb and biliopancreatic limb can be tailor-made according to the individual patient's metabolic profile for the desired effect.



Fig. 1: Sleeve Gastrectomy
(Adapted from Weight Management leaflet published by Department of Surgery, Yan Chai Hospital)



Fig. 2: Roux-en-Y Gastric Bypass
(Adapted from Weight Management leaflet published by Department of Surgery, Yan Chai Hospital)

Conventionally, MBS was believed to induce weight loss and glycemic control by restriction and malabsorption. Newer evidence suggested more complicated mechanisms involving interaction between food, gut hormones and the brain (gut-brain-axis)⁸. One of the notable gut hormones is Glucagon-Like-Peptide 1 (GLP-1), which is secreted by L cells of the ileum and colon in the presence of intraluminal nutrients. GLP-1 has an incretin effect, which stimulates insulin secretion in response to oral glucose and inhibits glucagon secretion in post prandial glycemic modulation. Additionally, GLP-1 is also associated with pancreatic β cell growth and inducing satiety via the central nervous system pathway⁹.

In RYGB, food intake is restricted by a small gastric pouch and reaches the distal jejunum and ileum more rapidly because of the bypassed jejunal segment. There is enhanced direct contact of nutrients in the ileum

with L cells and potentiates the secretion of GLP-1¹⁰. The shortened route from the gastric pouch to the distal ileum also expedites bile acid contact with ileum where more bile acid is reabsorbed, leading to elevated serum bile acid levels. Bile acid induces liver glycogen synthesis, inhibits gluconeogenesis and ameliorates insulin sensitivity¹¹.

Ghrelin is a growth hormone releasing peptide mainly secreted by oxyntic glands in the gastric fundus. It is an orexigenic (hunger) hormone that directly acts on the hypothalamus, stimulating appetite. It is normally suppressed after meals, but in obese subjects, such suppression is decreased¹². In addition, ghrelin has a negative effect on glucose metabolism by inhibiting adiponectin, an insulin sensitising hormone¹³.

In SG, fasting and post prandial ghrelin level is found to be significantly lower¹³, likely due to the complete removal of gastric fundus. In addition, the removal of a greater curve in SG accelerates gastric emptying, resulting in early delivery of nutrients to the ileum where secretion of gut hormones like GLP-1 is enhanced.

SAFETY OF METABOLIC AND BARIATRIC SURGERY

In 2023, more than 480,000 MBS procedures were performed across 24 countries. The reported perioperative mortality rate ranges from 0 % to 0.25 %. Median length of stay (LOS) ranges from 1 to 6 days⁷. In Hong Kong, according to the Surgical Outcomes Monitoring & Improvement Programme (SOMIP) report, no 30-day mortality is reported in the past ten years and the median LOS ranges from 3 to 5 days. Currently, seven public hospitals provide MBS service, one in each cluster¹⁴.

INDICATION FOR METABOLIC AND BARIATRIC SURGERY

A recent update in 2022 was published on indications for MBS by the American Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)¹⁵. MBS is recommended for patients with BMI ≥ 35 kg/m², regardless of co-morbidities, or BMI ≥ 30 kg/m², with T2DM. BMS should be considered in individuals with a BMI of 30 - 34.9 kg/m², with suboptimal weight loss or co-morbidity improvement by nonsurgical interventions. There is no more age limit for elderly patients who are eligible for MBS. There is a special consideration in the Asian population because the prevalence of T2DM and cardiovascular diseases is higher at a lower BMI. Therefore, the BMI threshold in Asians for MBS is adjusted to BMI ≥ 27.5 kg/m². American Diabetes Association also recommends MBS as a treatment option for T2DM with obesity, at a higher BMI threshold¹⁶.

CONTRAINDICATIONS FOR METABOLIC AND BARIATRIC SURGERY

There is no absolute contraindication for MBS as long as the patient is fit for general anaesthesia with underlying co-morbidities optimised. However, some patients are considered not suitable for MBS. To cite a few examples: uncontrolled mental health or behaviour problems like eating disorder/substance abuse or dependency; deemed non-compliant with life style and nutrition supplement requirements or cancer with limited life expectancy.

OUTCOMES OF METABOLIC AND BARIATRIC SURGERY

Metabolic and Bariatric surgery achieves durable superior glycemic control and weight loss compared with nonsurgical treatment. The landmark RCT¹⁷ (STAMPEDE trial) reported that at five years after surgery, 23 % and 29 % patients treated with SG and RYGB were able to achieve HbA1c ≤ 6 % while 5 % remission rate was reported in medical treatment group. Five-year weight loss from baseline was 23.2 kg, 18.5 kg and 5.3 kg in RYGB, SG and medical therapy groups respectively. A large observational study with 4,434 participants reported 68.2 % complete diabetic remission rate within 5 years after surgery, but 35.1 % had a recurrence. The median duration of remission was 8.3 years¹⁸. Long term T2DM remission rate, defined by HbA1c ≤ 6 % and diabetic medication free five years post BMS, after RYGB and SG, was reported in a review paper in which 4 RCTs were included. There was no significant difference between RYGB (50 %) and SG (43 %)¹⁹. A recent large meta-analysis with 174,772 participants reported that mean life expectancy was 9.3 years longer in diabetic patients who underwent MBS than their counterparts in the nonsurgical group. The author estimated that every 1 % increase in MBS utilisation rate can yield 5.1 million potential life-years in diabetic patients all over the world²⁰.

The initial cost of MBS may be high when compared with nonsurgical treatments; however, considering long term effectiveness and safety, surgery may be cost effective or even cost saving in diabetes patients²¹.

Due to the malabsorptive nature of MBS, patients are prone to develop micronutrient deficiency, depending on the type of procedure. Compliance with nutritional supplements and follow up with a multi-disciplinary team are essential.

CONCLUSION

Metabolic and Bariatric Surgery is a safe, effective, durable and cost-effective treatment modality for diabetes and should be discussed with eligible patients.

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MCHK CME Programme Self-assessment Questions

Please read the article entitled "Surgical Treatment of Adult Diabetes" by Dr CHAN Man-pan and complete the following self-assessment questions. Participants in the MCHK CME Programme will be awarded CME credit under the Programme for returning completed answer sheets via fax (2865 0345) or answer link: <https://forms.gle/35a0xpT7n657qTeX7> or by mail to the Federation Secretariat on or before 31 March 2024. Answers to questions will be provided in the next issue of The Hong Kong Medical Diary. (Address: Duke of Windsor Social Service Bldg., 4/F., 15 Hennessy Rd., Wan Chai. Enquiry: 2527 8898)

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

1. The global prevalence of obesity and diabetes has been steady in the past three decades.
2. Obesity is the primary risk factor for developing type 2 diabetes mellitus.
3. Obesity exacerbates the metabolic dysfunction associated with type 2 diabetes mellitus and vice versa.
4. Asian patients have a lower BMI threshold for metabolic and bariatric surgery than Western patients.
5. Sleeve Gastrectomy is the least performed metabolic and bariatric procedure worldwide.
6. Patients need to take life-long nutritional supplements after Rou-en-Y Gastric Bypass.
7. MBS achieves superior and durable glycemic control over nonsurgical treatment in the STAMPEDE trial.
8. Perioperative mortality in metabolic and bariatric surgery is less than 0.25 %.
9. Patients with BMI ≥ 35 kg/m² without co-morbidities can be offered bariatric surgery according to the latest guidelines.
10. Diabetic patients who underwent MBS have longer mean life expectancy than their nonsurgical counterparts.

ANSWER SHEET FOR MARCH 2024

Please return the completed answer sheet to the Federation Secretariat on or before 31 March 2024 for documentation. 1 CME point will be awarded for answering the MCHK CME programme (for non-specialists) self-assessment questions.

Surgical Treatment of Adult Diabetes

Dr CHAN Man-pan

MBBS(HK), FRCSEd(Gen), FCSHK, FHKAM(Surgery)

Specialist in General Surgery

Associate Consultant, Department of Surgery, Yan Chai Hospital

Present-elect, Hong Kong Obesity Society



Answer Link

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Name (block letters): _____ HKMA No.: _____ CDSHK No.: _____

HKID No.: ____ - ____ X X (X) HKDU No.: _____ HKAM No.: _____

Contact Tel No.: _____ MCHK No. / DCHK No.: _____ (must fill in)

Answers to February 2024 Issue

A Review and Update on Management of Degenerative Cervical Spine Disease

1. T 2. T 3. T 4. F 5. T 6. T 7. F 8. T 9. F 10. T

What is the **OPTIFAST®** program?

OPTIFAST® is a very-low calorie diet (VLCD) meal replacement program clinically proven for the management of overweight and obesity.

It replaces up to three meals each day with a range of low carbohydrate, high protein, shakes and soups.

How does a VLCD work?

A VLCD provides fewer calories than the body needs to function each day. This makes the body break down its stored fat to be used as energy through a process called **ketosis**.

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Clinically proven to produce rapid and substantial weight loss of up to **25 kg per week***



Improve blood glucose control and reduce the use of diabetes medications¹



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Improve blood pressure control²



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References

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sustained through 52 weeks of follow-up¹



Exploring Madagascar's Natural Wonders: Lemurs Park and the Enchanting Andasibe Reserve

Dr Tellus Man-yuk NG

MBChB(CUHK), MRCP(UK), FHKCP, FHKAM(Medicine)

President, Hong Kong Obesity Society
Specialist in Endocrinology Diabetes & Metabolism



Dr Tellus Man-yuk NG

Welcome, fellow adventurers, to a captivating narrative of our extraordinary expedition to the mesmerising island of Madagascar. In this enthralling tale, we embarked on a remarkable journey that took us to the enchanting Lemurs Park, where chameleons of all kinds dazzled us and lemurs playfully leaped onto our heads. But our adventure did not end there – we also ventured to the magical Andasibe Reserve, immersing ourselves in its lush rainforests and encountering unique wildlife.

LEMURS PARK - A HAVEN FOR LEMUR LOVERS

Our adventure began in the captivating Lemurs Park, a sanctuary dedicated to the conservation of Madagascar's beloved lemurs. As we stepped foot into this haven of natural beauty, we were greeted by a kaleidoscope of chameleons, showcasing their vibrant colours and intricate patterns. The chameleons' ability to seamlessly blend into their surroundings left us in awe of nature's artistry. But the true highlight awaited us as we encountered the playful lemurs. With their mischievous charm and boundless energy, they leaped onto our heads and shoulders, forging a connection that filled our hearts with joy and wonder.

ANDASIBE RESERVE - A RAINFOREST SYMPHONY

Our journey continued to the enchanting Andasibe Reserve, a pristine rainforest nestled in eastern Madagascar. As we ventured deep into its lush foliage, a symphony of sounds surrounded us the haunting calls of the indri lemurs, the melodious songs of endemic birds, and the rustling of leaves as elusive creatures traversed the forest floor. The reserve's diverse ecosystem revealed itself to us as we marvelled at the vibrant reptiles, including snakes with iridescent scales and curious amphibians hidden among the foliage. Amidst the tranquillity of the rainforest, we felt a profound connection with the natural world.

A FUSION OF FRENCH AND MALAGASY FLAVOURS

Despite the basic living standards of the locals, our taste buds were indulged in a delightful culinary journey that seamlessly blended French and Malagasy influences. We savoured the fusion of flavours that Madagascar had to offer. The tantalising aroma of French pastries mingled with the vibrant spices of local cuisine, creating

a symphony of taste. We relished the delicate balance of flavours in traditional Malagasy dishes while also appreciating the French culinary techniques that added a touch of sophistication. Each meal was a celebration of the island's rich cultural heritage, leaving us with a lasting impression of culinary bliss.

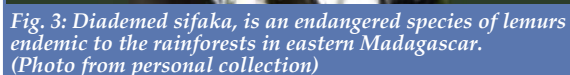
WORTH CONSIDERING: EXPLORING MADAGASCAR'S OTHER HIDDEN GEMS

If time was not limited, we would have considered additional Madagascar's hidden gems. Worthwhile locations include the following:

1. Tsingy de Bemaraha National Park: Situated in western Madagascar, this UNESCO World Heritage site is renowned for its unique limestone formations known as Tsingy. Exploring this otherworldly landscape promises awe-inspiring views and unforgettable adventures.
2. Masoala National Park: Located in the northeast, this pristine rainforest offers a chance to witness the elusive red-ruffed lemurs, endemic birds, and a mesmerising underwater world teeming with marine life. The park's remote location and untouched beauty make it a true paradise for nature enthusiasts.
3. Tsaratanana Reserve: Nestled in the far north, this reserve is home to Madagascar's highest peak and boasts an extraordinary array of flora and fauna. The rugged terrain and breathtaking vistas make it a haven for hikers and adventure seekers.



Fig. 1: Black and white ruffed lemur is an endangered species in Madagascar. (Photo from personal collection)



THE HONG KONG MEDICAL DIARY



Federation Annual Dinner 2023

The Federation Annual Dinner is one of the flagship events that the Federation holds every New Year's Eve to provide colleagues, friends, and families with an opportunity for fraternity and greeting the new year together, though it has been two years since our last year-end get-together due to the pandemic.

This year, the theme of the Federation Annual Dinner was "Federation, Sing and Shine!" It was full of exciting competitions and delightful performances for our guests not only to be admirable with their medical knowledge but to shine like diamonds with their outstanding singing techniques! We are lucky to have Dr Desmond Nguyen and Ms Ellen Ku, EXCO members of the Federation, to serve as Masters of Ceremony for the evening. Nearly 190 guests from our member societies and partners from the medical and healthcare communities attended our festive occasion.

We were privileged to have several distinguished guests joining us, including the following guests at our head table:

Prof Philip Li, Vice President (Education and Examinations) of the Hong Kong Academy of Medicine, and Mrs Lucinda Li;
Dr Hon David Lam, Legislative Council Member (Medical and Health Services), Functional Constituency;
Dr the Hon Edward Leong, GBM, GBS, OBE, JP;
Mr Hu Wenhua, Division Rank Official, The Liaison Office of the Central People's Government in the Hong Kong Special Administrative Region;
Dr York Chow, GBS, SBS, MBE, and Mrs Shelley Chow.

There were also representatives of member societies:

Dr Jenny Ngai, President of Hong Kong Thoracic Society;
Dr Yeung Yiu-cheon, President of CHEST Delegation Hong Kong and Macau;
Dr Fanny Ko, Chairman of Hong Kong Lung Foundation Limited;
Dr Lobo Louie, President of Sports Medicine and Sports Science Association of Hong Kong, China;
Dr Wendy Cheng, Honorary Secretary of Hong Kong Society for Emergency Medicine and Surgery; and
Dr Thomas Ling, Vice President of Hong Kong Society for Molecular Diagnostic Sciences Limited.

The presence of the above honourable guests brightened up the evening, and we owe them our genuine appreciation. To integrate the theme "Federation, Sing and Shine!" we were delighted to have Mr Ramon Lo, the 1st Runner-up of the 1st season of "Midlife, Sing & Shine!" to perform a few songs to lighten up the atmosphere of the evening. Throughout the evening, we had nine contestants compete in the singing competition, and we were delighted to have invited Dr Sylvia Chen, Dr York Chow and Ms Tina Yap as the panel of judges for the singing competition, which awarded the following winners:

Mrs Tammy Liu, competed with "Fly Me to the Moon", won the "最動人演繹獎";
Dr Peter Tsoi, competed with "L-O-V-E", won the "最佳情歌獎";
Dr Daniel Tam, competed with "My Way", won the "最佳演繹獎";
Mr Stephen Lee, competed with "Always on My Mind", won the "最佳經典情歌獎";
Ms Joyce Li, competed with "Colours of the Wind", won the "最具台風獎";
Dr Ludwig Tsoi, competed with "Can't Take My Eyes Off You", won the "最具人氣獎";
Dr Man Chi-wai, competed with a Japanese song "昂", won the "最佳外語歌曲獎";
Dr Mario Chak, competed with a Cantopop classic "天籟...星河傳說", won the "最佳電視劇主題曲獎"; and
Dr Victor Yeung, competed with another Cantopop classic "我的親愛", won the "最佳粵語歌曲獎".

There were also another few sets of singing performances by our beloved guests, including:

Mrs Linda Wong, performed "Love is a Many Splendored Thing";
Prof Paul Tam & Mrs Amy Tam, performed "Perhaps Love"; and
Dr Sylvia Chen, performed with "With One Look".

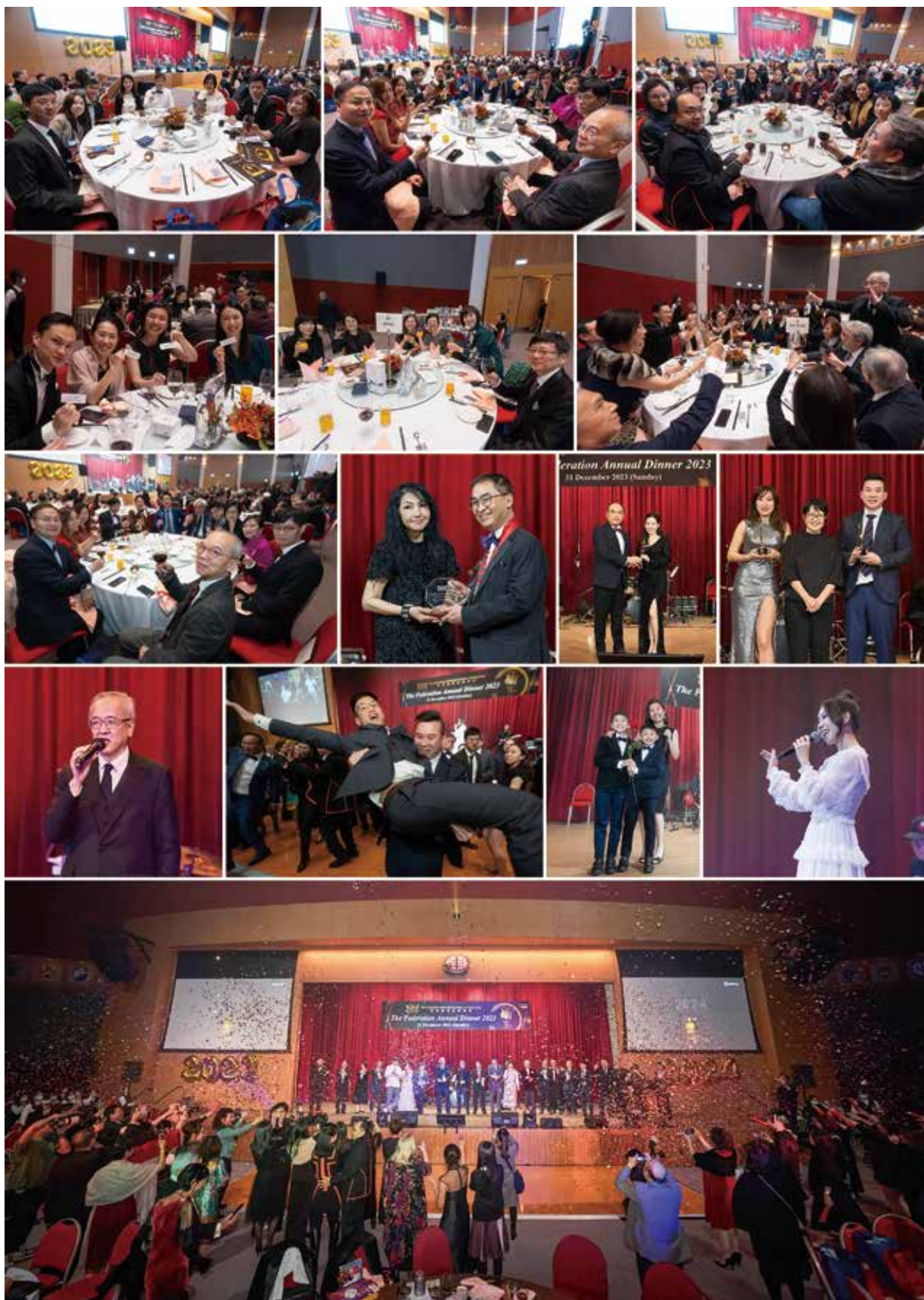
The finale of performance was "You Raise Me Up" led by Dr Sylvia Chen and sung by all performers and contestants.

Apart from the singing performances, everyone was thoroughly absorbed in the Bingo hosted by our very own Bingo Masters, Ms Tina Yap and Mr William Tsui; as well as in the Lucky Draw. Our guests turned into stars of the evening with Best Costume Awards and Dance Fever Awards. The atmosphere of the evening was brought to a climax with the countdown party and pop classics performed by EXCO members of the Federation, including our countdown tradition of "Auld Lang Syne", the "Federation Song" and the dragon dance as well.

Last but not least, it was a very pleasant night in which we shared our joy and excitement together. We express our sincere gratitude to all our sponsors, and special thanks to all the contestants, performers, as well as our guests for joining us on this remarkable occasion and for making this event possible.







Certificate Course in

Common Urological Problems 2024

(Video Lectures)

Jointly organised by



The Federation of Medical Societies of Hong Kong



Hong Kong Society of Practising Urologists

Objectives:

The course aims to equip the participants with knowledge on the following common urological conditions: 1. Urology problem of women in their fifty and above 2. Young men with erectile dysfunction & infertility 3. The approach to urinary tract stone 4. Dealing with difficult urinary tract infection & common urological diseases in children 5. Urinary tract cancers: a review & updates 6. Does prostate attribute to all lower urinary tract symptoms?



Date	Topics	Speakers
20 Mar 2024	Lower urinary tract symptoms in middle age women	Dr Cheung Ho Yuen Specialist in Urology
	Updates in management of urinary incontinence in women	Dr. Chung Yeung Vera Specialist in Urology
27 Mar 2024	Erectile dysfunction and infertility in young man	Dr. Mak Siu King Specialist in Urology
	Updates in management of male infertility	Dr. Ho Kwan Lun Specialist in Urology
3 Apr 2024	Updates in management of urinary tract stone	Dr. Cheung Man Chiu Specialist in Urology
	New technique in surgical treatment of renal stone	Dr. Li Churk Fai Trevor Specialist in Urology
10 Apr 2024	Updates in management of complicated urinary tract infection	Dr. Cheung Man Hung Phoebe Specialist in Urology
	Updates in common urological diseases in children	Dr. Kan Wai Man Raymond Specialist in Urology
17 Apr 2024	Prostate cancer: a review & updates	Dr Ma Wai Kit Specialist in Urology
	Common urological cancers associated with hematuria	Dr. Yeung Hip Wo Victor Specialist in Urology
24 Apr 2024	Updates in management of lower urinary tract symptoms in men	Dr. Fan Chi Wai Specialist in Urology
	New treatment modalities in benign prostatic hyperplasia	Dr. Lam Pei Wayne Specialist in Urology

Dates : 20, 27 March & 3, 10, 17, 24 April, 2024 (Wednesday)

Time : 7:00 pm – 8:30 pm

Duration of Session : 1.5 hours (6 sessions)

Course Feature : Video lectures (with Q&A platform for participants to post the questions)

Language Media : Cantonese (Supplemented with English)

Quiz for Doctors : DOCTORS are required to complete a quiz after the completion of each lecture

Course Fee : HK\$1,000

Certificate : Awarded to participants with a minimum attendance of 70% (4 out of 6 sessions)

Deadline : 13 March 2024

Enquiry : The Secretariat of The Federation of Medical Societies of Hong Kong

Tel: 2527 8898

Fax: 2865 0345

Email : toto.chan@fmshk.org



CME / CNE Accreditation in application

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The Hong Kong Association of Rehabilitation Medicine (HKARM)

It is our great pleasure and honour for the Hong Kong Association of Rehabilitation Medicine to join as an ordinary member of the Federation of Medical Societies of Hong Kong.

HKARM was formally established in 1997 by a group of doctors with interest and enthusiasm in the field of rehabilitation medicine. The mission of the association is to advance and promote the science, art and practice of rehabilitation medicine and its allied disciplines.

Mission & Objectives

- To promote education and research in rehabilitation medicine
- To increase the awareness of the roles and contributions of rehabilitation specialists
- To provide a platform of communication and collaboration for all local practitioners in rehabilitation
- To cooperate and maintain close liaison with other international societies in rehabilitation medicine
- To provide information to local government on good and evidence-based practices in rehabilitation
- To advocate for local policies that will enhance activities and participation of disabled persons in the community

Council members

President: Dr LAM Siu-pui
 Vice-president: Dr KOK Ching
 Hon Secretary: Dr Gina FONG
 Hon Treasurer: Dr Eric YEUNG
 Council members: Drs Thomas CHENG, KWOK Tsz-kin, Teresa YU, YUEN Ka-hong, Eddie CHOW, Carmen HO, Jennifer MYINT, Angus CHU, Thomas CHENG, Sophia TENG, Yukie TSE, YEUNG Pui-yu

HKARM is a member of the International Society of Physical and Rehabilitation Medicine (ISPRM) and the Asian Oceania Society of Physical & Rehabilitation Medicine (ASOPRM).

Our Activities

(1) Inter-hospital rehabilitation meetings

We conduct the bimonthly inter-hospital rehabilitation meetings in which a hybrid mode has been adopted since COVID. The meeting forms an integral part of training for young specialists and provides a platform for academic exchange for all healthcare professionals.

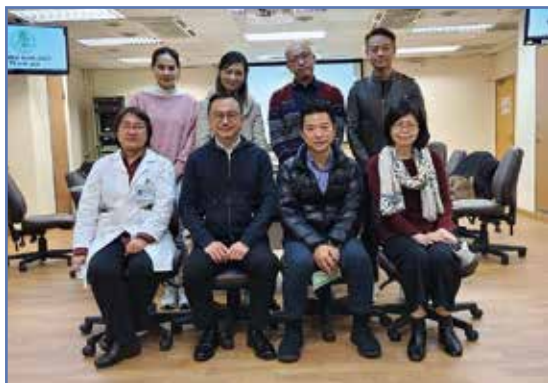
(2) Annual Scientific / Educational Meetings

We conduct annual scientific meetings with previous themes included pre-habilitation, cognitive rehabilitation, pulmonary rehabilitation, swallowing, technology in neurological rehabilitation and in the advances in rehabilitation medicine. In addition, we have conducted special lectures and symposiums presented by international and local professors in related fields. The topics in recent years include osteoporosis management, telemedicine in cardiovascular diseases and stroke management.

(3) RTHK rehabilitation series

In the past years, the HKARM had been invited by RTHK to launch a series of radio programme and interviews by our specialists on rehabilitation topics including cardio-pulmonary, COVID, neurological, musculoskeletal rehabilitation and mental well-being.

HKARM has been the supporting organization to local and regional conferences organized by other societies which promotes academic exchange and sharing among different society members.



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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
3	4	* In-person / Zoom HKMA-HKSH CME Programme 2023-2024 Topic: Pre-eclampsia Screening in Pregnancy	* Zoom The HKMA CME Live Lecture Topic: Managing the Dilemma: Patients with IBS/FD/GERD Overlap	* Zoom The HKMA CME Live Lecture Topic: Respiratory Syncytial Virus (RSV) Infections Amongst Infants: Burden, Risk Prevention Strategies and Management	1	2
10	11	* In-person The HKMA DHN CME Programme Topic: Update in Management of Degenerative Spine	* The Hong Kong Neurosurgical Society Monthly Academic Meeting - To be confirmed * In-person / Zoom HKMA-CUHK Medical Centre CME Programme 2024 Topic: Swallowing Disorder Amongst Elderly	* In-person / Zoom HKMA-HKSTP CME Programme 2023 Topic: To-be-confirmed	* Zoom The HKMA CME Live Lecture Topic: Non-invasive Tests for Prevention and Risk Reduction of Colonic Polyps and Colorectal Cancer - Recent Advancement and Case Sharing	9
17	18	* In-person / Zoom HKMA-GHK CME Programme 2024 Topic: Topic on Upper Gastrointestinal and Esophageal Surgery	* Zoom The HKMA CME Live Lecture Topic: Intensive Cholesterol Lowering for Plaque Regression - The Journey to Reverse Atherosclerosis * Certificate Course in Common Urological Problems 2024 (Video Lectures)	* In-person The HKMA DHN CME Programme Topic: Differential Clinical Advantages of Antidepressant for Better Management of Depression	* Zoom The HKMA CME Live Lecture Topic: Managing Common Urological Issues for Paediatric and Adult Patients	* In-person The HKMA Women's Health Campaign CME Symposium Topic 1: What is new in the 2024 HKCOG Guidelines for Cervical Cancer Prevention and Screening? Topic 2: Why is Menopause a Public Health Problem? * Certificate Course in Common Urological Problems 2024 (Video Lectures)
24	25	* In-person The HKMA DHN CME Programme Topic: Influenza - The Latest Update	* Zoom The HKMA CME Zoom Lecture Topic: Breakthroughs from Gut and Skin Microbiome Analyses Drive Enhanced Eczema Management	* FMSHK Executive Committee Meeting	22	23
31					29	30

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CV: cardiovascular; RRR: relative risk reduction; ADA: American Diabetes Association; EASD: European Association for the Study of Diabetes; CVD: cardiovascular disease; OAD: oral antidiabetic drug; T2DM: type 2 diabetes mellitus
Reference: 1. Zinman B, et al. N Engl J Med. 2015;373(22):2117-2118. 2. Jardiance Hong Kong Prescribing Information. 3. Davies MJ, D'Alessio DA, Fradkin J, et al. Management of hyperglycaemia in type 2 diabetes, 2018. A consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetologia. 2018.

[†] JARDIANCE demonstrated RRR in CV death in adult patients with insufficiently controlled type 2 diabetes (baseline HbA1c 7-10%) and established CV disease (coronary artery disease, peripheral artery disease, or a history of myocardial infarction or stroke).

[‡] Standard of care included CV medications and glucose-lowering agents, given at the discretion of physicians.

[§] Empagliflozin versus placebo on top of standard of care.

[#] Management of hyperglycaemia in type 2 diabetes, 2018. A consensus report by the ADA and EASD stated that among patients with established CVD, there is likely cardiovascular benefit, with the evidence of benefit modestly stronger for empagliflozin than canagliflozin.

^{*} Established CV disease included coronary artery disease, peripheral artery disease, history of myocardial infarction, or history of stroke

[^] Statistically significant

JARDIANCE® Abbreviated Prescribing Information (aPI-JARD-03)

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ESTABLISHED CV DISEASE^{2**}**



Date / Time	Function	Enquiry / Remarks
5 TUE 1:00 PM	In-person / Zoom HKMA-HKSH CME Programme 2023-2024 Topic: Pre-eclampsia Screening in Pregnancy Organiser: The Hong Kong Medical Association and the Hong Kong Sanatorium & Hospital Speaker: Dr CHAN Wan-pang Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point
6 WED 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Managing the Dilemma: Patients with IBS/FD/GERD Overlap Organiser: The Hong Kong Medical Association Speaker: Dr CHAU Wai-ming	HKMA CME Dept. Tel: 3108 2507 1 CME Point
7 THU 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Respiratory Syncytial Virus (RSV) Infections Amongst Infants: Burden, Risk Prevention Strategies and Management Organiser: The Hong Kong Medical Association CUHK-Centre for Health Education & Health Promotion Speaker: Prof Ellis Kam-lun HON	HKMA CME Dept. Tel: 3108 2507 1 CME Point
11 MON 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Personalised Asthma Management with Once-Daily Single Inhaler Triple Therapy (SITT) Organiser: The Hong Kong Medical Association Speaker: Dr Terence Chi-chun TAM	HKMA CME Dept. Tel: 3108 2507 1 CME Point
12 TUE 2:00 PM	In-person The HKMA DHN CME Programme Topic: Update in Management of Degenerative Spine Organiser: The HKMA District Health Network Speaker: Dr Eric Cheung-hing LAM Venue: Ballroom III, 2/F, Courtyard by Marriott Hong Kong Shatin, 1 On Ping Street, Shatin, HK	HKMA CME Dept. Tel: 3108 2507 1 CME Point
13 WED 7:30 AM	The Hong Kong Neurosurgical Society Monthly Academic Meeting - To be confirmed Organiser: Hong Kong Neurosurgical Society Speaker(s): Dr Hannaly Cheuk-hang LUI Chairman: Dr CHAN Kwong-yau Venue: Conference Room, F2, Department of Neurosurgery, Queen Elizabeth Hospital; or via Zoom meeting	College of Surgeons of Hong Kong Dr Calvin MAK Tel: 2595 6456 Fax. No.: 2965 4061 1.5 CME Points
13 WED 1:00 PM	In-person / Zoom HKMA-CUHK Medical Centre CME Programme 2024 Topic: Swallowing Disorder Amongst Elderly Organiser: The Hong Kong Medical Association CUHK-Medical Centre Speaker: Dr Wency Wan-sze HO Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point
14 THU 1:00 PM	In-person / Zoom HKMA-HKSTP CME Programme 2023 Topic: To-be-confirmed Organiser: The Hong Kong Medical Association and The Hong Kong Science and Technology Park Speaker: To-be-confirmed Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point
15 FRI 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Non-invasive Tests for Prevention and Risk Reduction of Colonic Polyps and Colorectal Cancer - Recent Advancement and Case Sharing Organiser: The Hong Kong Medical Association Speaker: Dr CHOW Chi-wing	HKMA CME Dept. Tel: 3108 2507 1 CME Point
18 MON 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Non-Alcoholic Fatty Liver Disease: How Can We Do Better? Organiser: The Hong Kong Medical Association Speaker: Dr SZE Wan-chee	HKMA CME Dept. Tel: 3108 2507 1 CME Point
19 TUE 2:00 PM	In-person / Zoom HKMA-GHK CME Programme 2024 Topic: Topic on Upper Gastrointestinal and Esophageal Surgery Organiser: The Hong Kong Medical Association and The Gleneagles Hong Kong Hospital Speaker: Dr Patricia Po-chu YAM Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point
20 WED 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Intensive Cholesterol Lowering for Plaque Regression - The Journey to Reverse Atherosclerosis Organiser: The Hong Kong Medical Association Speaker: Dr Victor King-man GOH	HKMA CME Dept. Tel: 3108 2507 1 CME Point
20 WED 7:00 PM	Certificate Course in Common Urological Problems 2024 (Video Lectures) Organiser: The Federation of Medical Societies of Hong Kong Speaker: Dr CHEUNG Ho-yuen, Dr Vera Yeung CHUNG	Ms ToTo CHAN Tel: 2527 8898
21 THU 2:00 PM	In-person The HKMA DHN CME Programme Topic: Differential Clinical Advantages of Antidepressant for Better Management of Depression Organiser: The HKMA District Health Network Speaker: Dr Raymond Ka-yau WONG Venue: The HKMA Wanchai Premises, 5/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point



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Composition (active): Naltrexone HCl 8mg & Bupropion HCl 90mg. **Indication:** As an adjunct to a reduced-calorie diet and increased physical activity, for the management of weight in adult patients an initial BMI of ≥ 30 kg/m² or ≥ 27 kg/m² in the presence of one or more weight-related co-morbidities. **Dosage:** Escalate dose over a 4-week period from initiation. Maintenance dose from week 4 onward is 2 tab in the morning and 2 tab at night. **Contraindications:** Hypersensitivity, uncontrolled hypertension, seizure disorder or a history of seizures, CNS tumour, acute alcohol or benzodiazepine withdrawal, history of bipolar disorder, use of concomitant treatment containing bupropion or naltrexone, current or previous diagnosis of bulimia or anorexia nervosa, currently dependent on chronic opioids or opiate agonists, or patients in acute opiate withdrawal, severe hepatic impairment, end-stage renal failure, and in concomitant administration with MAOI. **Precautions:** Suicidal ideation, seizure, controlled hypertension, active coronary artery disease or history of cerebrovascular disease, predisposing factors that increase risk of seizure, history of mania, concurrent use with SSRIs or SNRIs. **Adverse Reactions:** Nausea, constipation, vomiting, dizziness, headache, dry mouth. **References:** 1. Contrave[®] Product Information. 2. Biles SK, et al. Pharmacol Res 2014;84(1-1). 3. Australian and New Zealand Obesity Society, Australian Obesity Management Algorithm. Available at: www.anzso.com/publications (accessed October 2020). 4. Duromine Product Information. 5. Saxenda Product Information. 6. Orlistat ARTG Public Summary. 7. Yumuk V, et al. Obes Facts 2015;8:402-424. 8. Acosta A, et al. Obesity 2021;29:662-671. 9. Greenway FL, et al. Lancet 2010;376:595-605. 10. Fujioka K, et al. Int J Obes 2016;40:1369-1375.

⁷For weight management as an adjunct to diet and exercise, EMA=European Medicines Agency; US FDA= US Food and Drug Administration.

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HK-2023-10-0022



Date / Time	Function	Enquiry / Remarks
21 THU 8:00 PM	FMSHK Executive Committee Meeting Organiser: The Federation of Medical Societies of Hong Kong; Venue: Council Chamber, 4/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai, Hong Kong	Ms Nancy CHAN Tel: 2527 8898
22 FRI 2:00 PM	Zoom The HKMA CME Live Lecture Topic: Managing Common Urological Issues for Paediatric and Adult Patients Organiser: The Hong Kong Medical Association Speaker: Dr John Hin-kay NGAN	HKMA CME Dept. Tel: 3108 2507 1 CME Point
23 SAT 1:00 PM	In-person The HKMA Women's Health Campaign CME Symposium Topic 1: What is new in the 2024 HKCOG Guidelines for Cervical Cancer Prevention and Screening? Topic 2: Why is Menopause a Public Health Problem? Organiser: The Hong Kong Medical Association Speaker: Dr NGU Siu-fei & Prof Carmen WONG Venue: Shantung Room, Level 8, Cordis, Hong Kong, 555 Shanghai Street, Mongkok, Kowloon, Hong Kong	HKMA CME Dept. Tel: 3108 2507 2 CME Points
7:00 PM	Certificate Course in Common Urological Problems 2024 (Video Lectures) Organiser: The Federation of Medical Societies of Hong Kong Speaker: Dr MAK Siu-king, Dr HO Kwan Lun	Ms ToTo CHAN Tel: 2527 8898
25 MON 2:00 PM	Zoom The HKMA CME Zoom Lecture Topic: Personalised Patient Care and Long Term Management of Endometriosis Organiser: The Hong Kong Medical Association Speaker: Dr LUI Kwai-ying	HKMA CME Dept. Tel: 3108 2507 1 CME Point
26 TUE 2:00 PM	In-person The HKMA DHN CME Programme Topic: Influenza - The Latest Update Organiser: The HKMA District Health Network Speaker: Dr Wilson LAM Venue: Diamond 3-6, 2/F, Crowne Plaza Hong Kong Kowloon East, 3 Tong Tak Street, Tseung Kwan O, Hong Kong	HKMA CME Dept. Tel: 3108 2507 1 CME Point
27 WED 2:00 PM	Zoom The HKMA CME Zoom Lecture Topic: Breakthroughs from Gut and Skin Microbiome Analyses Drive Enhanced Eczema Management Organiser: The Hong Kong Medical Association Speaker: Prof LEUNG Ting-fan	HKMA CME Dept. Tel: 3108 2507 1 CME Point

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Answers to Dermatology Quiz

Answers:

1. The clinical diagnosis is lichen striatus. The differential diagnoses include linear lichen planus, linear epidermal naevi, segmental vitiligo, hypomelanosis of Ito and incontinentia pigmenti.

Lichen striatus is an uncommon self-limited linear dermatosis of unknown aetiology. It is mainly a disease of children, with predominance in females. More than half of all cases occurred between 5 - 15 years of age. Though rare, it can also occur in adults. The onset is often abrupt with mildly itchy or asymptomatic reddish lichenoid papules, which then coalesce to form a slightly scaly linear band. Lesions most commonly distribute unilaterally along the lines of Blaschko (not dermatome) of one arm or leg. In rare cases, it can occur on the face, neck or trunk. The inflammatory phase usually lasts for a few weeks before being resolved in post-inflammatory hypopigmentation or hyperpigmentation. Occasionally, nails may be affected, and the involvement is almost always confined to one single nail. Atopy may be a predisposing factor.

2. Lichen striatus is mainly diagnosed on clinical grounds based on its typical appearance and characteristic developmental pattern following the lines of Blaschko. Skin biopsy is usually unnecessary, except occasionally done to exclude linear lichen planus.
3. Apart from reassurance, treatment is usually not necessary in most patients with lichen striatus. Emollients and topical steroids may be used if patients have dryness or itchiness.
4. Lichen striatus is a self-limited disorder with an excellent prognosis. The lesions usually spontaneously regress within 6 - 12 months, though the hypopigmentation or hyperpigmentation may last for several months to years.

Dr CHONG Lai-yin

MBBS(HK), FRCP(Lond, Edin, Glasg), FHKCP, FHKAM(Med)
Specialist in Dermatology & Venereology

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OG = Obstetricians & Gynecologists.

[^]According to 2021 survey by Kantar HK. Respondents are doctors

(Specialist in Obstetrics & Gynecology). Sample size N=51.

References: 1. Chin Chua M, et al. JPN 2017;65:102-6. 2. Phavichitr et al. Scientific Reports, 2021; 11:3534. 3. Martin R et al. Appl Environ Microbiol 2009;75:965-969. 4. Wong C, B et al. Nutrients 2019; 5. Coulter L et al. 2009; J. Agric. Food Chem.;57, 8488- 8495. 6. Boehm G, et al. (2003) Acta Paediatr Suppl. 91(441):64-7. 7. Stahl B et al. Anal Biochem 1994; 223:218-226.

Important Notice: Breast-feeding is the best form of nutrition for babies and provides many benefits to babies and mothers. It is important that, in preparation for and during breast-feeding, pregnant and lactating women eat a healthy, balanced diet. Combined breast and bottle-feeding in the first weeks of life may reduce the supply of their own breast-milk, and reversing the decision not to breast-feed is difficult. Always consult healthcare professional for advice about feeding baby. If infant formula is used, mothers / care givers should follow manufacturer's instructions for use carefully. Failure to follow the instructions may make baby ill. The social and financial implications of using infant formula should be considered. Improper use of an infant formula or inappropriate foods or feeding methods may present a health hazard.

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Adolescents (≥12 years): Saxenda[®] can be used as an adjunct to a healthy nutrition and increased physical activity for weight management in adolescent patients from the age of 12 years and above with obesity (BMI corresponding to ≥30 kg/m² for adults, by IOTF BMI cutoff points) and body weight above 60 kg. Treatment with Saxenda[®] should be discontinued and re-evaluated if patients have not lost at least 4% of their BMI or BMI z score after 12 weeks on the 3.0 mg/day or maximum tolerated dose. **Dosage:** Adults: The starting dose is 0.6 mg once daily. The dose should be increased to 3.0 mg daily in increments of 0.6 mg with at least one week interval to improve gastrointestinal tolerability. Titration to the next dose step is not tolerated for two consecutive weeks, consider discontinuing treatment. Adolescents (≥12 years): For adolescents from the age of 12 to below 18 years old a similar dose escalation schedule as for adults should be applied. The dose should be increased until 3.0 mg (maintenance dose) or maximum tolerated dose has been reached. Adults and Adolescents: Daily doses higher than 3.0 mg are not recommended. Method of administration: Saxenda[®] is for subcutaneous use only. It must not be administered intravenously or intramuscularly. Saxenda[®] is administered once daily at any time, independent of meals, preferably around the same time of the day. It should be injected in the abdomen, thigh or upper arm. Saxenda[®] should not be used in combination with another GLP-1 receptor agonist. When initiating Saxenda[®] in patients with type 2 diabetes mellitus, consider to reduce the dose of concomitantly administered insulin or insulin secretagogues (such as sulfonylureas) to reduce the risk of hypoglycaemia. Blood glucose self-monitoring is necessary to adjust the dose of insulin or insulin secretagogues. The safety and efficacy of Saxenda[®] in children below 12 years of age has not been established. **Contraindications:** Hypersensitivity to liraglutide or to any of the excipients. **Special warnings and precautions:** There is no clinical experience in patients with congestive heart failure, New York Heart Association (NYHA) class IV, and Saxenda[®] is therefore not recommended for use in these patients. Use of Saxenda[®] is not recommended in patients with inflammatory bowel disease and diabetic gastroparesis. Saxenda[®] is not recommended in patients, aged 75 years or more, treated with other products for weight management, with obesity secondary to endocrinological or eating disorders or to treatment with medicinal products that may cause weight gain, with severe renal impairment, with severe hepatic impairment. Saxenda[®] must be used with caution in patients with mild or moderate hepatic impairment. Acute pancreatitis has been observed with the use of GLP-1 receptor agonists. Patients should be informed of the characteristic symptoms of acute pancreatitis. If pancreatitis is suspected, Saxenda[®] should be discontinued; if acute pancreatitis is confirmed, Saxenda[®] should not be restarted. In clinical trial for weight management, a higher rate of chills/rhinitis and cholelithiasis was observed in patients treated with Saxenda[®] than in patients on placebo. Patients should be informed of the characteristic symptoms of chills/rhinitis and cholelithiasis. In clinical trials in type 2 diabetes, thyroid adverse events, such as goitre, have been reported in particular in patients with pre-existing thyroid disease. Saxenda[®] should therefore be used with caution in patients with thyroid disease. An increase in heart rate was observed with liraglutide in clinical trials. Heart rate should be monitored at regular intervals consistent with usual clinical practice. Patients should be informed of the symptoms of increased heart rate (palpitations or feelings of a racing heartbeat while at rest). For patients who experience a clinically relevant sustained increase in resting heart rate, treatment with Saxenda[®] should be discontinued. Patients treated with Saxenda[®] should be advised of the potential risk of dehydration in relation to gastrointestinal side effects and take precautions to avoid fluid depletion. Patients with type 2 diabetes mellitus receiving Saxenda[®] in combination with insulin and/or sulfonylureas may have an increased risk of hypoglycaemia. The risk of hypoglycaemia may be lowered by a reduction in the dose of insulin and/or sulfonylureas. Episodes of clinically significant hypoglycaemia have been reported in adolescents (≥12 years) treated with liraglutide. Patients should be informed about the characteristic symptoms of hypoglycaemia and the appropriate actions. In patients with diabetes mellitus, Saxenda[®] must not be used as a substitute for insulin. Diabetic ketoacidosis has been reported in insulin-dependent patients after rapid discontinuation or dose reduction of insulin. Dizziness can be experienced mainly during the first 3 months of treatment with Saxenda[®]. Driving or use of machines should be exercised with caution if dizziness occurs. **Pregnancy and lactation:** Saxenda[®] should not be used during pregnancy or breast-feeding. If a patient wishes to become pregnant or pregnancy occurs, treatment with Saxenda[®] should be discontinued. **Undesirable effects:** Very common (≥1/10): headache, nausea, vomiting, diarrhoea, constipation. Common (≥1/100 to <1/10): hypoglycaemia, insomnia, dizziness, dysgeusia, dry mouth, dyspepsia, gastritis, gastro-oesophageal reflux disease, abdominal pain, urticaria, eruption, abdominal distension, chills/rhinitis, injection site reactions, asthenia, fatigue, increased appetite, increased appetite, uncommon (≥1/1,000 to <1/100): dehydration, tachycardia, pancreatitis, delayed gastric emptying, cholelithiasis, urticaria, malaise. Rare (≥1/10,000 to <1/1,000): anaphylactic reaction, acute renal failure, renal impairment. **Overdose:** From clinical trials and marketed use overdoses have been reported up to 72 mg (24 times the recommended maintenance dose). Events reported included severe nausea, severe vomiting and severe hypoglycaemia. In the event of overdose, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms. The patient should be observed for clinical signs of dehydration and blood glucose should be monitored. Date of revision: Jun 2023

References: 1. Saxenda Hong Kong Prescribing Information (B9556-05-001-3) 2. Lishitz F. Obesity in children. J Clin Res Ped Endo. 2008;1(2):53-60. 3. Kelly AS, Auerbach P, Barrientos-Perez M, et al. A randomized, controlled trial of liraglutide for adolescents with obesity. N Engl J Med. 2020;382:117-128. 4. Data on file: Novo Nordisk Inc.; Plainsboro, NJ.



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