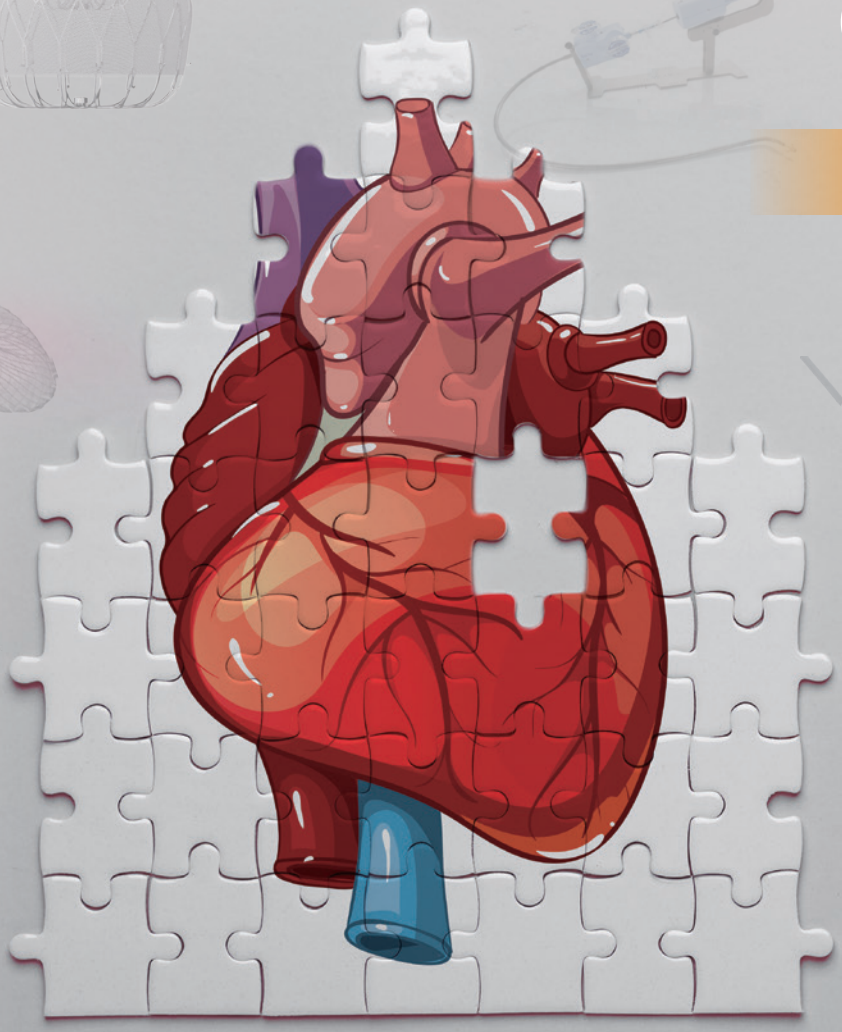
12th Asia Pacific Congenital and Structural Heart Intervention Symposium

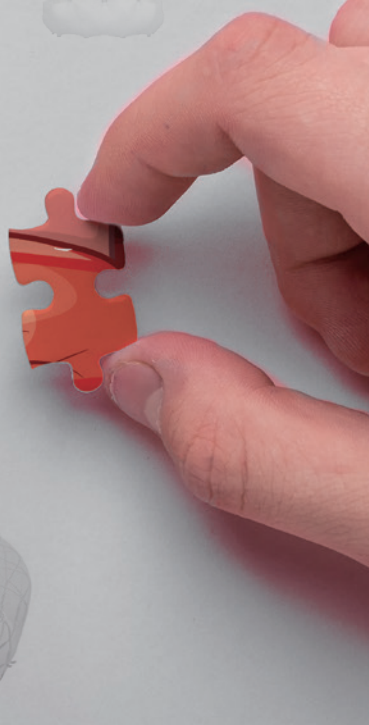
APCASH 2022

3-4 DECEMBER 2022

HYBRID

PROGRAM BOOK





Organized by:

Supported by:

Analysis of the TVT Registry supports safety and efficacy of Edwards SAPIEN 3 TAVI aortic THV-in-THV procedures in patients at high or greater risk for open heart surgery[1]

Baseline Characteristics	n=263
Age (years)	78.9 ± 10.5
STS score	10.2 ± 8.6
NYHA Class III/IV	87.7%

Procedural Event	n=263
Device implanted successfully	98.9%
Procedure aborted	0.0%
Conversion to open heart surgery	0.8%

Event	30 Days (n=263)	1 Year (n=263)
All-cause mortality	5.8%	18.2%
Cardiovascular mortality	2.7%	5.4%
All stroke	2.3%	2.8%
New pacemaker	8.2%	10.6%
Moderate/Severe PVL	4.5%	2.6%

Achieve your Higher Standard for aortic THV-in-THV procedures with SAPIEN 3 TAVI.

1. TVT Registry Analysis, SAPIEN 3 and SAPIEN 3 Ultra valve, THV-in-THV aortic procedures, N=263. Edwards Lifesciences data on file.

CAUTION: For professional use only. See Instructions for Use for full prescribing information, including indications, contraindications, warnings, precautions and adverse events.

Edwards Lifesciences Pty Ltd • 2/4 Talavera Road North Ryde NSW 2113 Australia • Ph: 1800 222 601
Edwards Lifesciences (New Zealand) Ltd • PO Box 28658 Remuera New Zealand • Ph: 0800 222 601

Edwards

Table of Contents

JARDIANCE - NOW APPROVED* for HFpEF in Hong Kong

IMPACT HEART FAILURE LIKE NEVER BEFORE

The 1st and only medicine approved* to reduce the risk of CV death or HHF in symptomatic chronic heart failure across the LVEF spectrum‡§[1-3]

25% RRR LVEF ≤ 40%^[2]

21% RRR LVEF > 40%‖[1]

Established safety and tolerability profile[1-3]

Simple dosing: oral, 10 mg once daily, no titration#[3]

Recognizing EMPEROR-Reduced and EMPEROR-Preserved trial **JARDIANCE** is recommended across the LVEF spectrum**[4]

Jardiance® (empagliflozin)

* Approved = Jardiance 10mg is indicated in adults for the treatment of symptomatic chronic heart failure in Hong Kong

‡ Adult patients with chronic heart failure (NYHA class II, III, or IV) and reduced ejection fraction (LVEF ≤ 40%). Adult patients with chronic heart failure (NYHA class II, III, or IV) and preserved ejection fraction (LVEF > 40%).[1,2]

§ In the EMPEROR-Preserved trial, a randomised, double-blind, parallel-group, placebo-controlled study of 5988 patients with HFpEF, the efficacy and safety of JARDIANCE 10 mg (n=2997) were evaluated vs placebo (n=2991). The primary endpoint in the EMPEROR-Preserved trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 21% RRR in this endpoint (HR=0.79; 95% CI: 0.69, 0.90; p<0.001). In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[1,2]

^ In the EMPEROR-Reduced trial, a randomised, double-blind, parallel-group, placebo-controlled study of 3730 patients with HFrEF, the efficacy and safety of JARDIANCE 10 mg (n=1863) were evaluated vs placebo (n=1867). The primary composite endpoint in the EMPEROR-Reduced trial was a composite of CV death or HHF, analysed as time to the first event. Patients treated with JARDIANCE experienced a 25% RRR in this endpoint (HR=0.75; 95% CI: 0.65, 0.86; p<0.001).[2]

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When Jardiance is used in combination with a sulphonylurea or with insulin, a lower dose of the sulphonylurea or insulin may be considered to reduce risk of hypoglycaemia.[3]

** The SGLT2i class, such as Jardiance, has gained a 1A recommendation for HFrEF and a 2a-B-R recommendation for HFmrEF and HFpEF.[4]

CI=confidence interval; CV=cardiovascular; HFpEF=heart failure with preserved ejection fraction; HFrEF=heart failure with reduced ejection fraction; HFmrEF=heart failure with mid range ejection fraction; HHF=hospitalisation for heart failure; HR=hazard ratio; LVEF=left ventricular ejection fraction; NYHA=New York Heart Association; RRR=relative risk reduction; SGLT2i=sodium-glucose cotransporter 2 inhibitor

JARDIANCE® Abbreviated Prescribing Information (aPI-JARD-02)

Presentation: Empagliflozin. Film-coated tablets 10 mg; 25 mg. **Indications: 10 mg and 25 mg:** Indicated in the treatment of type 2 diabetes mellitus to improve glycaemic control in adults as: monotherapy when diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance; and as add-on combination therapy with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control. Indicated in patients with type 2 diabetes mellitus and established cardiovascular disease to reduce the risk of cardiovascular death. **10 mg:** Jardiance is indicated in adults for the treatment of symptomatic chronic heart failure. **Dosage and administration: Type 2 diabetes mellitus:** 10 mg once daily. In patients tolerating 10 mg once daily and requiring additional glycaemic control, the dose can be increased to 25 mg once daily. Can be taken with or without food. No dose adjustment is required for patients with eGFR ≥ 30 mL/min/1.73m² or with hepatic impairment, or for elderly patients. **Heart Failure:** 10 mg once daily. Can be taken with or without food. In HF patients with or without T2DM, 10 mg may be initiated or continued down to an eGFR of 20 ml/min/1.73m² or CrCl of 20 ml/min. **Contraindication:** Hypersensitivity to empagliflozin or any of the excipients. For the treatment of Type 2 diabetes, JARDIANCE should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis, as glycaemic efficacy depends on renal function. **Special warnings and precautions:** Should not be used in patients with type 1 diabetes or for treatment of ketoacidosis. Discontinue immediately when ketoacidosis is suspected or diagnosed. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses, and may be restarted once the patient's condition has stabilised. For type 2 diabetes mellitus, should not be used in patients with severe renal impairment (eGFR <30 mL/min/1.73m²), end-stage renal disease and patients on dialysis. For HF, not recommended for use when eGFR < 20 mL/min/1.73m². Discontinue in cases of recurrent UTI. Due to a risk of modest decrease in blood pressure, caution should be exercised in patients with known cardiovascular disease, patients on diuretics, patients with history of hypotension or patients aged 75 years and older. Monitoring of volume status and electrolytes is recommended. Regularly examine the feet and counsel patients on routine preventative footcare. Caution is advised in patients at increased risk of genital infections. Avoid use during pregnancy and breast-feeding. Safety and effectiveness in children under 18 years of age have not been established. Initiation is not recommended in patients aged 85 years and older. Urine will test positive for glucose while patients are taking JARDIANCE. **Interactions:** Risk of dehydration and hypotension may increase when used in combination with thiazide and loop diuretics. Lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with JARDIANCE. **Adverse reactions:** Hypoglycaemia (depends on type of background therapy of patients); Urinary tract infection, vaginal moniliasis, vulvovaginitis, balanitis and other genital infection; Increased urination, dysuria; Pruritus; Volume depletion; Thirst; Glomerular filtration rate decreased, blood creatinine increased, haematocrit increased, serum lipids increased. Post-marketing experience: Ketoacidosis, complicated urinary tract infections, necrotising fasciitis of the perineum (Fournier's gangrene), allergic skin reaction, angioedema. **Storage condition:** Please refer to outer packaging for special precautions for storage. **Note:** Before prescribing, please consult full prescribing information.

References: 1. Anker SD, Butler J, Filippatos G, et al; EMPEROR-Preserved Trial Investigators. Empagliflozin in heart failure with a preserved ejection fraction. N Engl J Med. 2021;385(16):1451-1461. (EMPEROR-Preserved results and the publication's Supplementary Appendix.) **2.** Packer M, Anker SD, Butler J, et al; EMPEROR-Reduced Trial Investigators. Cardiovascular and renal outcomes with empagliflozin in heart failure. N Engl J Med. 2020;383(15):1413-1424. (EMPEROR-Reduced results and the publication's Supplementary Appendix.) **3.** Jardiance Hong Kong Prescribing Information. **4.** Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA guideline for the management of heart failure: executive summary: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines [Epub ahead of print]. J Am Coll Cardiol. 2022. doi:10.1016/j.jacc.2021.12.011

PC-HK-100758 (Jun 2022)

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12th APCASH - Program-at-a-glance

The program is at Hong Kong Time (GMT+8).

	3 December 2022 (Day 1)		4 December 2022 (Day 2)	
	Room 1 (N101A)	Room 2 (N101B)	Room 1 (N101A)	Room 2 (N101B)
AM Session	Congenital Session (VSD Occlusion) I		When Imagers Meet Interventionist	Mechanical Circulatory Support in SHD
	Break		Break	
	Congenital Session (VSD Occlusion) II		How will You Treat? Interventionist and Surgeon Collaboration	The Role of Nurses in SHI
			SHI - The Asian Perspective (Joint session with China Structural Week, ENCORE SEOUL, Structure Club Japan)	Challenging Case Competition
PM Session	Focus on MV Interventions		Lunch Sponsored Symposium	
	Opening Ceremony		Keynote Lecture – "My 20-year journey of TAVI" *Prof. Lars SØNDERGAARD*	
	Sponsored Symposium		Break	
	Live Cases - Focus on ICE/LAAO	Congenital Session - Pulmonary Valve Intervention	Complication Forum - Master the Bailout!	
	Break		Closing Remarks	
	Live Cases - Focus on TV	The Role and Challenges of Anesthetist in SHI		

** The program is subject to change without prior notice.*

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Advanced Therapy for Tricuspid Regurgitation

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- Two self-expanding valves
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- Specifically designed for SVC and IVC
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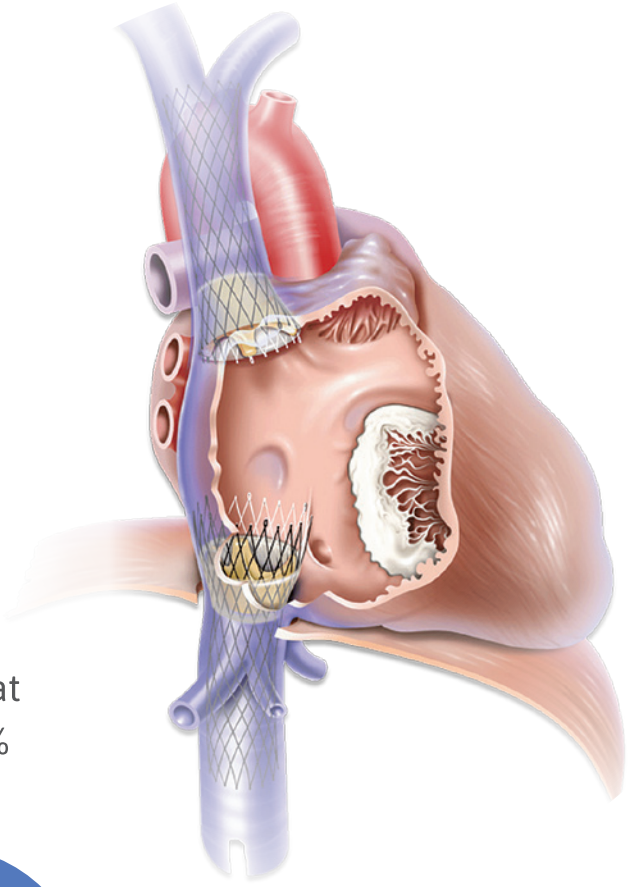
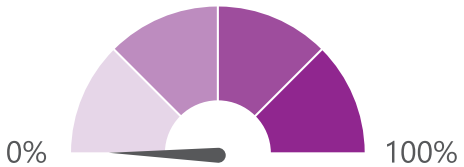
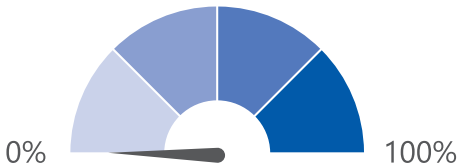


SAFETY AND EFFICACY*

Data from the Early Feasibility Trial showed that In-Hospital mortality was 0% and Stroke/TIA 0%



0%
In hospital mortality



0%
Stroke/TIA

Improving quality of life for patients with severe tricuspid regurgitation, inoperable or high risk for surgical therapies

* Device and procedure related
Dr Amat Santos. H. Clinico Universitario Valladolid, ICICORELAB
AICT AsiaPCR, 2020

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Welcome Message from 12th APCASH Program Directors

On behalf of the Organizing Committee, we are greatly honored and pleased to welcome you all to the 12th Asia Pacific Congenital and Structural Heart Intervention Symposium (APCASH 2022). We are delighted to see many of our friends and colleagues from abroad and Hong Kong to share their invaluable insights and expertise.

APCASH is a fast-growing meeting dedicated to congenital and structural interventions in the Asia Pacific region. Over the past few years, the conference has been well known for live case transmissions and taped case demonstrations from renowned hospitals worldwide. We believe our participants will gain substantial knowledge through learning from the experts around the globe.

This year, the 2-day program will focus on structural and congenital live cases from Spain and Taiwan; the joint force meeting with cardiologists, cardiac surgeons, cardiac anesthetists, intensivists and cardiac nurses; mechanical circulatory support in SHD; when imagers meet interventionists; and debate on whether transcatheter VSD occlusion should be adopted as the GOLD standard treatment. We have taped case sharing and keynote lecture from Hong Kong and international experts bringing to you the latest advances in interventional therapeutics for both paediatric and structural heart diseases and discussion of various strategies and techniques.

APCASH 2022 Keynote Lecture will be delivered by Professor Lars Søndergaard who is professor of cardiology at the University of Copenhagen and consultant cardiologist at Rigshospitalet in Denmark.

We would like to express our deepest gratitude to the supporting organizations for their staunch and steadfast support to this year's meeting again. Their contributions to promote exchange of ideas and clinical experiences have been invaluable.

Our heartfelt gratitude also goes to our sponsors for their generous support, without which this conference would not have been possible.

We hope you all will enjoy our program and find it rewarding.

Jason LK CHAN **Robin HS CHEN** **Gary SH CHEUNG** **Shing-Fung CHUI**

Program Directors, 12th APCASH

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Transcatheter Edge-to-Edge Repair

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About HKCASH

The Hong Kong Society of Congenital & Structural Heart Disease (HKCASH), founded in August 2007, is an academic organization in Hong Kong that aims to promote, maintain and pursue excellence in the care of patients with congenital and structural heart diseases. The society is dedicated to the advancement of knowledge and training in medical disciplines pertinent to above-mentioned diseases. To accomplish this mission, the society hosts regular professional academic meetings, introduces education materials to the patients and the general public throughout the year.

The primary activity of the HKCASH will be conducting an annual meeting for healthcare professionals. The Asia Pacific Congenital & Structural Heart Intervention Symposium is an annual conference that is attended by dedicated healthcare professionals from Asia Pacific region.

For details of HKCASH and its membership, please visit ***www.hongkongcash.org***

90mg

Improved outcomes matter

BRILINTA® ticagrelor tablets

IN MI PATIENTS, THE SUPERIORITY[1]* OF BRILINTA™ VS CLOPIDOGREL CAN MAKE THE DIFFERENCE

Reduction in CV events[1†]

-16%

p<0.001

Reduction in CV death[1]

-21%

p=0.001

Reduction in MI[1]

-16%

p=0.005

2020 ESC Guideline recommendations for antithrombotic treatment in NSTE-ACS patients without atrial fibrillation undergoing PCI[2]

Recommendations	Class	Level
A P2Y12 receptor inhibitor is recommended in addition to aspirin and maintained over 12 months unless there are contraindications or an excessive risk of bleeding. Options are:	I	A
BRILINTA™ irrespective of the planned treatment strategy (invasive or conservative) (180 mg LD, 90 mg b.i.d.)‡.	I	B

In 2021 ESC guidelines on cardiovascular disease prevention, prasugrel or BRILINTA™ is preferred as standard antithrombotic treatment after ACS for 12 months as DAPT[4].

2016 ACC/AHA Guideline focused update on duration of dual antiplatelet therapy in patient with coronary artery disease[3]

Recommendations	Class	Level
In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after coronary stent implantation and in patients with NSTE-ACS treated with medical therapy alone (without revascularization), it is reasonable to use BRILINTA™ in preference to clopidogrel for maintenance P2Y12 inhibitor therapy.	IIa	B-R
In patients with ACS (NSTE-ACS or STEMI) treated with DAPT after BMS or DES implantation, P2Y12 inhibitor therapy (clopidogrel, prasugrel, or BRILINTA™) should be given for at least 12 months.	I	B-R
In patients with ACS who are managed with medical therapy alone (without revascularization or fibrinolytic therapy) and treated with DAPT, P2Y12 inhibitor therapy (clopidogrel or BRILINTA™) should be continued for at least 12 months.	I	B-R

* The PLATO study was a multicentre, randomized, double-blind trial. 18,624 patients admitted to the hospital with an ACS, with or without ST-segment elevation were randomized to receive either BRILINTATM (180 mg loading dose, 90 mg twice daily thereafter) or clopidogrel (300 to 600 mg loading dose, 75 mg daily thereafter) for the prevention of cardiovascular events for 12 months. All patients receive aspirin at a dose of 75 to 100 mg/day unless they could not tolerate the drug. The primary efficacy variable was the time to the first occurrence of composite of death from vascular causes, myocardial infarction, or stroke. The principal secondary efficacy end point was the primary efficacy variable studied in the subgroup of patients for whom invasive management was planned at randomization[1].

† CV events=CV death, MI, or stroke.

‡ Other options include prasugrel and clopidogrel.

ACC=American College of Cardiology. ACS=acute coronary syndrome. AHA=American Heart Association. BMS=bare metal stent. CAD=coronary artery disease. CV=cardiovascular. DAPT=dual antiplatelet therapy. DES=drug-eluting stent. EACTS=European Association for Cardio-Thoracic Surgery. EASD=European Association for the Study of Diabetes. ESC=European Society of Cardiology. MI=myocardial infarction. NSTE-ACS=non-ST elevation-acute coronary syndrome. PCI=percutaneous coronary intervention. STEMI=ST-segment elevation myocardial infarction.

References: 1. Wallentin L, et al. N Engl J Med. 2009; 361:1045-1057. 2. Collet JP, et al. Eur Heart J. 2021;42:1289-1367. 3. Levine GN, et al. Journal of the American College of Cardiology. 2016;68(10):1082-1115. 4. Visseren FLJ, et al. European Heart Journal. 2021;42(34):3227-3337.

Please visit contactazmedical.astrazeneca.com, for (1) enquiring Medical Information (MI), (2) reporting Individual Case Safety Report (ICSR) and/or (3) reporting Product Quality Complaint (PQC) to AstraZeneca Hong Kong Limited.

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Presentation: Ticagrelor 90mg / 60mg film-coated tablet. Indication: Co-administered with aspirin, for prevention of atherothrombotic events in adult patients with ACS; or a history of myocardial infarction (MI) and a high risk of developing an atherothrombotic event. Dosage: Should be taken with 75-150mg aspirin daily, unless specifically contraindicated. For ACS patients, initiated with a single 180mg loading dose and then continued at 90mg twice daily for 12 months unless discontinuation is clinically indicated. For patients with a history of MI of at least one year and a high risk of an atherothrombotic event, when extended treatment is required, 60mg twice daily recommended. Contraindications: Hypersensitivity to any ingredients of this product; Active pathological bleeding; History of intracranial haemorrhage; Severe hepatic impairment; Co-administration with strong CYP3A4 inhibitors e.g. ketoconazole, clarithromycin, nefazodone, ritonavir, and atazanavir. Precautions and Interactions: Children <18 years; Pregnancy and lactation. Patients with a propensity to bleed; Concomitant use of medicinal products that may increase the risk of bleeding within 24 hours of dosing or known to alter haemostasis e.g. antifibrinolytic therapy and/or recombinant factor VIIa; Stop for 7-day before surgery; Moderate hepatic impairment; Patients at risk for bradycardic events; Concomitant use of medicinal products known to induce bradycardia; History of asthma and/or COPD; Patients ~75 years; Moderate/severe renal impairment; Concomitant treatment with an ARB; History of hyperuricaemia or gouty arthritis; Uric acid nephropathy; High aspirin maintenance dose (>300mg); Premature treatment discontinuation; Co-administration with potent CYP3A inducers e.g. rifampicin, phenytoin, carbamazepine and phenobarbital; Co-administration with CYP3A4 substrates with narrow therapeutic indices i.e. cisapride and ergot alkaloids; Patients on renal dialysis; Concomitant use of simvastatin or lovastatin ~40mg; Medicinal products metabolised by CYP3A4; CYP3A4 substrates with narrow therapeutic indices; Cyclosporine; SSRIs e.g. paroxetine, sertraline and citalopram. Undesirable effects: Blood disorder bleedings (bruise, spontaneous haematoma, haemorrhagic diathesis), hyperuricaemia, dyspnoea, gout/gouty arthritis, dizziness, syncope, headache, vertigo, hypotension, respiratory system bleedings (epistaxis, haemoptysis), gastrointestinal haemorrhage (gingival bleeding, rectal bleeding, gastric ulcer haemorrhage), diarrhea, nausea, dyspepsia, constipation, subcutaneous or dermal bleeding (ecchymosis, skin haemorrhage, petechiae), rash, pruritus, urinary tract bleeding (haematuria, cystitis haemorrhage), blood creatinine increased, post procedural haemorrhage, traumatic bleedings (contusion, traumatic haematoma, traumatic haemorrhage). Full local prescribing information is available upon request. API.HK.BRIL90.0816 BRIL60.0516

HK-6322 27/11/2021 4C_2103C

Organizing Committee

A Note of Appreciation from the Organizing Committee

The Organizing Committee would like to express its sincerest gratitude to all parties and individuals, including delegates, sponsors, speakers, and the secretariat, who have joined us in delivering the Symposium. The Committee hopes that all would find this Symposium inspiring and informative and looks forward to your continued support in the years to come.

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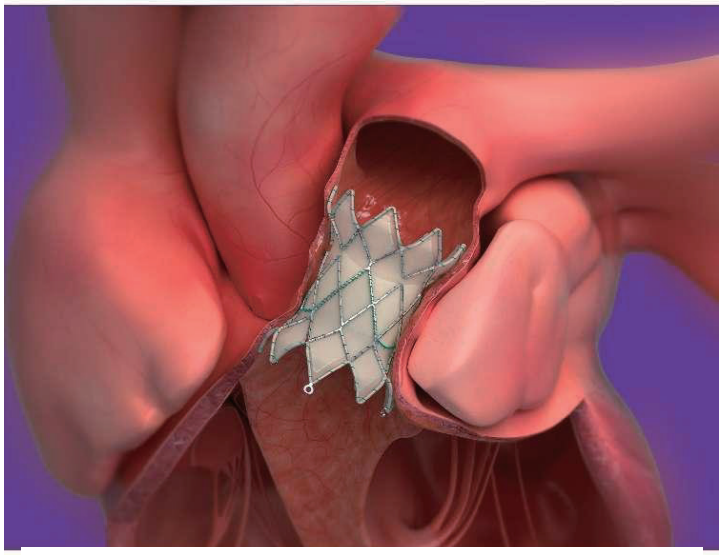
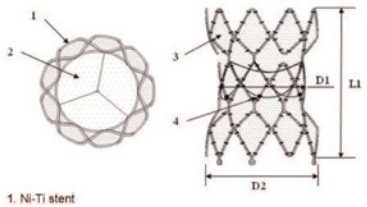


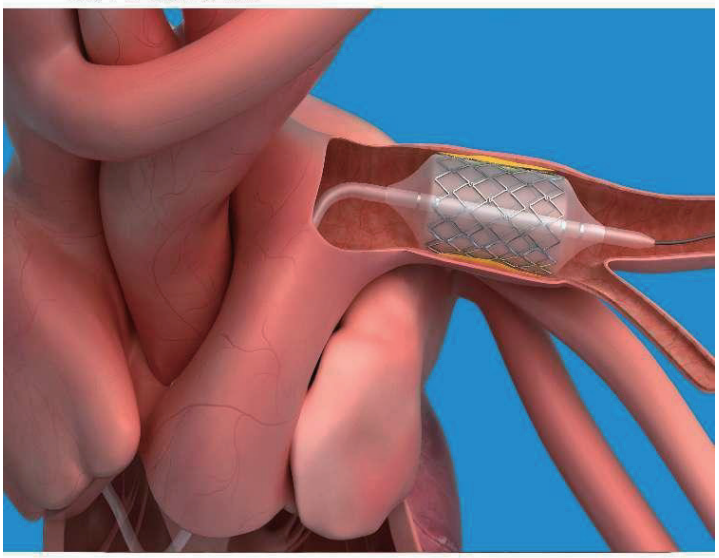


1. Ni-Ti stent
2. Leaflet
3. Seal membrane
4. Radiography marker

Specification	D1(mm)	D2(mm)	L1(mm)
TPV2820	20	28	38
TPV3223	23	32	42
TPV3626	26	36	46
TPV4026		40	50
TPV4426		44	54

Med-Zenith™ PUL-stent™

• Only For Clinical Trial



Stent Model	Dia. Range	Length					
		15 mm	20 mm	25 mm	30 mm	35 mm	40 mm
S	6 mm – 12 mm	PAS.S15	PAS.S20	PAS.S25	PAS.S30	PAS.S35	PAS.S40
M	12 mm – 16 mm	/	PAS.M20	PS.M25	PAS.M30	PAS.M35	PAS.M40
L	18 mm – 22 mm	/	PAS.L20	PAS.L25	PAS.L30	PAS.L35	PAS.L40

迈迪顶峰
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Supporting Organizations

12th APCASH would like to thank the following Supporting Organizations for their staunch support:

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HCMC Pediatric Cardiology and Congenital Heart Disease Society

Hong Kong College of Cardiology

The Hong Kong Cardiac Nursing Association

Hong Kong Society of Paediatric Cardiology

Hong Kong Society of Transcatheter Endo-cardiovascular Therapeutics

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International Faculty

Dr. Teiji AKAGI
Adult Congenital Heart Disease Center
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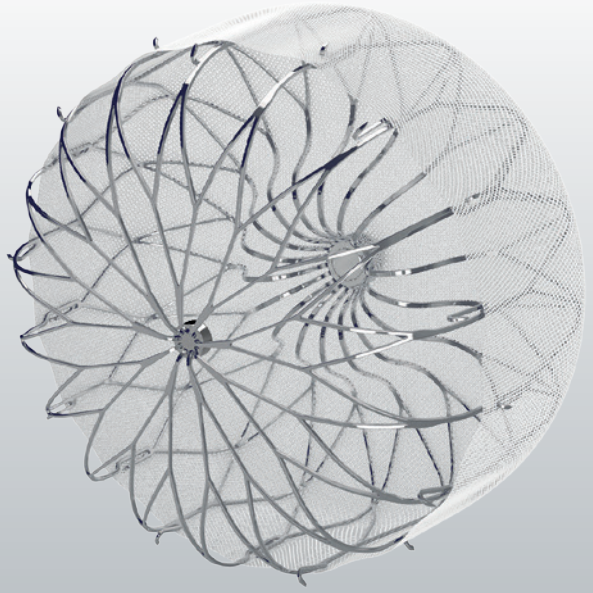

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(As at date of printing)

Scientific Program (Day 1)

3 December 2022

Room 1 (N101A)			Room 2 (N101B)		
Time	Pressentation Topic	Speaker	Time	Pressentation Topic	Speaker
08:30	Registration				
09:00-10:30	**Congenital Session (VSD Occlusion) I**				
	Moderators: Dr. Robin HS CHEN, Dr. Pak-Cheong CHOW, Dr. Worakan PROMPHAN				
	Discussants: Dr. Gi-Beom KIM, Prof. Jieh-Neng WANG				
	One year outcome of device closure of subarterial VSD comparing with surgical closure	Dr. Supaporn ROYMANEE			
	Role of biodegradable VSD occluders	Dr. Xiang-Bin PAN			
	Challenging cases in VSD occlusion	Prof. Jou-Kou WANG			
	Live Case from National Taiwan University Hospital				
10:30-10:45	Coffee Tea Break				
10:45-12:30	**Congenital Session (VSD Occlusion) II**				
	Moderators: Dr. Robin HS CHEN, Dr. Dora ML WONG, Dr. Nicholson YAM				
	Discussants: Dr. Mazeni ALWI, Dr. Kin-Shing LUN, Dr. Lan Hieu NGUYEN, Dr. Yu-Mei XIE, Dr. Xin LI				
	Debate! Transcatheter VSD occlusion should be adopted as the GOLD standard firstline treatment for perimembranous VSD (Pro)	Dr. Nguyen Tin DO			
	Debate! Transcatheter VSD occlusion should be adopted as the GOLD standard firstline treatment for perimembranous VSD (Con)	Dr. Sivakumar SIVALINGAM			
	Round Table Discussion				
	Live Cases from National Taiwan University Hospital				
12:30 - 13:30	**Focus on MV Interventions**				
	Moderators: Dr. Simon CC LAM, Dr. Kent CY SO				
	Panelists: Dr. Eric KY CHAN, Dr. Boron CW CHENG, Dr. Shih-Hsien SUNG, Dr. Minoru TABATA, Dr. Wen-Loong YEOW				
	TMVR for native MR - are we there yet?	Dr. Scott LIM			
	The remaining problems and solutions of VIV/VIR/VIMAC TMVR	Dr. Marvin ENG			
	Comparison of different new transcatheter mitral valve repair technology	Dr. Saibal KAR			
	Discussion				
13:30-13:50	Break				

Scientific Program (Day 1)

13:50-14:00	**Opening Ceremony**			
	Welcome Speech	Dr. Gary SH CHEUNG		
14:00-14:50	**Sponsored Symposium**			
	Moderators: Dr. Kevin KH KAM, Dr. Gabriel WK YIP			
	Panelists: Dr. Anna KY CHAN, Prof. Chung-Seung CHIANG, Dr. Godwin TC LEUNG			
	New approach to ACS patients with high ischemic risks - Evidence on extended use of DAPT *(Sponsored by AstraZeneca Hong Kong Ltd.)*	Dr. Kevin KH KAM		
	Lipid lowering treatment for AMI patients - How early and how low? *(Sponsored by Sanofi Hong Kong Ltd.)*	Dr. Chun-Ka WONG		
	Evidence and practical consideration on in-hospital initiation of SGLT2 inhibitors for heart failure *(Sponsored by Boehringer Ingelheim (Hong Kong) Ltd.)*	Dr. Yiu-Kwan KO	14:30-16:00	**Congenital Session - Pulmonary Valve Intervention**
	Discussion			Moderators: Dr. Maria SH LEE, Dr. Tak-Cheung YUNG
14:50-15:00	Break			Panelists: Dr. Bharat V DALVI, Dr. K. SIVAKUMAR
15:00-16:00	**Live Cases - Focus on ICE / LAAO**			My tPVR algorithm — Dr. Worakan PROMPHAN
	Moderators: Dr. Gary SH CHEUNG, Dr. Vincent NH LUK			Real world data on self-expandable valves — Dr. Gi-Beom KIM
	Discussants: Dr. Raymond CY FUNG, Dr. Ryan LY KO, Dr. Simon CC LAM, Dr. Jacqueline SAW, Dr. Ivan MH WONG			Predictive prevision in percutaneous pulmonary valve implantation — Dr. Phuoc DUONG
	Updates on clinical data of LAAO	Prof. Jens Erik NIELSEN-KUDSK		Preliminary feasibility data on Med Zenith PT valve *(Sponsored by Beijing Med-Zenith Medical Scientific Co. Ltd.)* — Dr. Robin HS CHEN
	Advancement in imagings for LAAO	Dr. Apostolos TZIKAS		Future perspective of percutaneous pulmonary valve implantation — Prof. Shakeel QURESHI
	New advancement in LAAO devices	Dr. Yoshifumi NAKAJIMA		Discussion
	Live Case from Spain			
16:00-16:30	Coffee Tea Break *(Sponsored by Edwards Lifesciences Hong Kong Ltd.)*			
16:30-18:30	**Live Cases - Focus on TV**		16:30-17:30	**The Role and Challenges of Anesthetist in SHI**
	Moderators: Dr. Yat-Yin LAM, Dr. Kent CY SO			Moderators: Dr. Danny HF CHOW, Dr. Gabriel WK YIP
	Discussants: Dr. Eric KY CHAN, Dr. Kam-Tim CHAN, Prof. Song WAN			Panelists: Dr. Joe KT LEE
	Assessment of TR and imaging evaluation of different treatments	Prof. Alex PW LEE		Anesthetic challenges in alternative access TAVI — Dr. Linda ML LAI
	Transcathter tricuspid valve replacement	Prof. Thomas MODINE		Anesthetic challenges in severe MR complicating low EF — Dr. Jason TY LAI
	Other Transcatheter Technologies to Treat TR	Prof. Horst SIEVERT		Anesthetic challenges in tricuspid valve interventions — Dr. Tanya WS YAU
	Live Case from Spain			Discussion

Scientific Program (Day 2)

4 December 2022

Room 1 (N101A)			Room 2 (N101B)		
Time	**Pressentation Topic**	**Speaker**	**Time**	**Pressentation Topic**	**Speaker**
08:00	Registration				
08:30-09:30	**When Imagers Meet Interventionist**		08:30-09:30	**Mechanical Circulatory Support in SHD**	
	Moderators: Dr. Joe KT LEE, Dr. Kevin KH KAM			Moderators: Dr. Kam-Tim CHAN, Dr. Shing-Fung CHUI	
	Panelists: Dr. Adrian YY CHEONG, Dr. Daisuke HACHINOHE, Dr. Reda IBRAHIM, Dr. Eric CY WONG, Dr. Francis SF YIU			Panelists: Dr. Michael CS CHIANG, Dr. Ho LAM, Dr. Sunny CF TSANG	
	How advanced imaging guide my complex mitral / tricuspid valve intervention?	Dr. Dee-Dee WANG		Role of MCS in AS/AR	Dr. Pedro VILLABLANCA
	How advanced imaging guide my complex LAA Closure	Dr. Jacqueline SAW		Role of MCS in MR	Dr. Guson KANG
	Preprocedural and procedural considerations of ICE-guided LAAO procedure *(Sponsored by Boston Scientific Hong Kong Ltd.)*	Dr. Raymond CY FUNG		Right heart support	Dr. Alejandro LEMOR
	Discussion			Discussion	
09:30-10:00	**Recorded Live Case - TAVI in Challenging Bicuspid Anatomy**	Dr. Simon CC LAM	09:30-10:30	Break	
10:00-10:30	Coffee Tea Break				
10:30-11:30	**How will You Treat? Interventionist and Surgeon Collaboration**		10:30-11:30	**The Role of Nurses in SHI**	
	Moderators: Dr. Daniel TL CHAN, Dr. Simon CC LAM			Moderator: Dr. Gabriel WK YIP	
	Panelists: Dr. Shing-Fung CHUI, Dr. Vincent WS NG, Dr. Hon-Chi SUEN			Panelists: Dr. Kevin KH KAM, Dr. Joe KT LEE, Ms. Hei-Man LO	
	Minimal invasive mitral valve repair of complex DMR	Dr. Daniel TL CHAN		Structural heart coordinator - the US experience	Dr. Janet WYMAN
	Transcatheter treatment of AF TR	Dr. Saibal KAR		Role of cath lab nurses in SH interventions - Hong Kong experience	Mr. Chak-Yuen WONG
	Outcomes of Surgical Tricuspid Valve intervention: 15 years experience of a single institution	Prof. Randolph HL WONG		Role of SH nurse coordinators - Hong Kong experience	Ms. Mei-Yi CHAU
	Transcatheter treamtent of pure AR	Prof. Jian YE		My vision on the role of nurses in SHI development	Ms. Cecilia MC CHAN
	Discussion			Discussion	
11:30-12:30	**SHI - The Asian Perspective (Joint Session with China Structural Week, ENCORE SEOUL, Structure Club Japan)**		11:30-13:00	**Challenging Case Competition**	
	Moderators: Dr. Yat-Yin LAM, Dr. Kent CY SO			Moderators: Dr. Robin HS CHEN, Dr. Gary SH CHEUNG	
	Panelists: Dr. Yu-Ho CHAN, Dr. Do-Yoon KANG, Dr. Vincent OH KWOK, Prof. Yong-Joon LEE, Dr. Shu-Kin LI, Dr. Yohei OHNO, Dr. Shinichi SHIRAI			Judges: Dr. Andy WK CHAN, Dr. Jacqueline SAW, Dr. Eugene B WU, Dr. Reda IBRAHIM, Dr. Kam-Tim CHAN, Prof. Jing-Ming WU, Prof. Jieh-Neng WANG	
	SHI in Japan and Asia - Where are we now?	Dr. Kentaro HAYASHIDA		(9) Successful rescue of ruptured aortic annulus during transcatheter aortic valve replacement	Dr. Ivan MH WONG
	How Asian's AS are different?	Prof. Mao CHEN		(7) Trans-caval LAVA ECMO supported TMVR (in extreme PAD patient with severe MR & cardiogenic shock)	Dr. Michael CS CHIANG
	How Asian's MR/TR are different?	Dr. Sang-Yeub LEE		(2) Transcatheter right ventricular outflow tract stenting in low birth weight infant with TOF	Dr. Abdul Aziz FARHA

Scientific Program (Day 2)

11:30-12:30	Do we have new innovations?	Dr. Jian-An WANG	11:30-13:00	(1) Atrial fibrillation in patients with congenital heart disease- Where do we stand?	Prof. Wei-Syun HU
	Discussion			(12) All roads lead to Rome: The first transcaval TAVI in Hong Kong	Dr. Leo KL LAI
12:30-13:00	**Recorded Live Case - Challenging MitraClip**	Dr. Kent CY SO		(11) Stenting in pulmonary atresia /VSD	Dr. Neeraj AGGARWAL
				(13) All roads lead to Rome: The first transcarotid TAVI in Hong Kong	Dr. Simon CY CHOW
13:00-14:00	**Lunch Sponsored Symposium**				
	Moderators: Dr. Kam-Tim CHAN, Dr. Shing-Fung CHUI				
	Panelists: Dr. Alan KC CHAN, Dr. Ka-Lung CHUI, Dr. Steven SL LI				
	Navitor: A new solution for TAVR with active PVL sealing technology *(Sponsored by Abbott Medical (HK) Ltd.)*	Prof. Stephen WORTHLEY			
	How to improve durability of TAVR valve *(Sponsored by Medtronic Hong Kong Medical Ltd.)*	Dr. Michael CS CHIANG			
	Considerations in contemporary TAVR - Bicuspid aortic valves and lifetime strategy *(Sponsored by Edwards Lifesciences Hong Kong Ltd.)*	Dr. Gerald YONG			
	Discussion				
14:00-14:30	**Recorded Live Case - Tricuspid** *(Sponsored by OrbusNeich Medical Co. Ltd.)*	Dr. Shing-Fung CHUI			
14:30-15:15	**Keynote Lecture**				
	Moderators: Dr. Gary SH CHEUNG, Dr. Vincent NH LUK				
	Panelists: Dr. Danny HF CHOW, Dr. Patrick TH KO, Dr. Ivan MH WONG				
	My 20-year journey of TAVI	Prof. Lars SØNDERGAARD			
	Roundtable Discussion				
15:15-15:45	Coffee Tea Break				
15:45-16:45	**Complication Forum - Master the Bailout!**				
	Moderators: Dr. Danny HF CHOW, Dr. Shing-Fung CHUI				
	Panelists: Dr. Teiji AKAGI, Dr. Kelvin KW CHAN, Dr. Gary SH CHEUNG, Dr. Kin-Lam TSUI				
	My worst TAVI complication	Prof. Wei-Hsian YIN			
	My worst LAAO complication	Dr. Hidehiko HARA			
	My worst TEER complication	Dr. Takashi MATSUMOTO			
	My worst congenital intervention complication	Prof. Ziyad HIJAZI			
	Discussion				
16:45-17:00	**Closing Remarks**	Dr. Robin HS CHEN			

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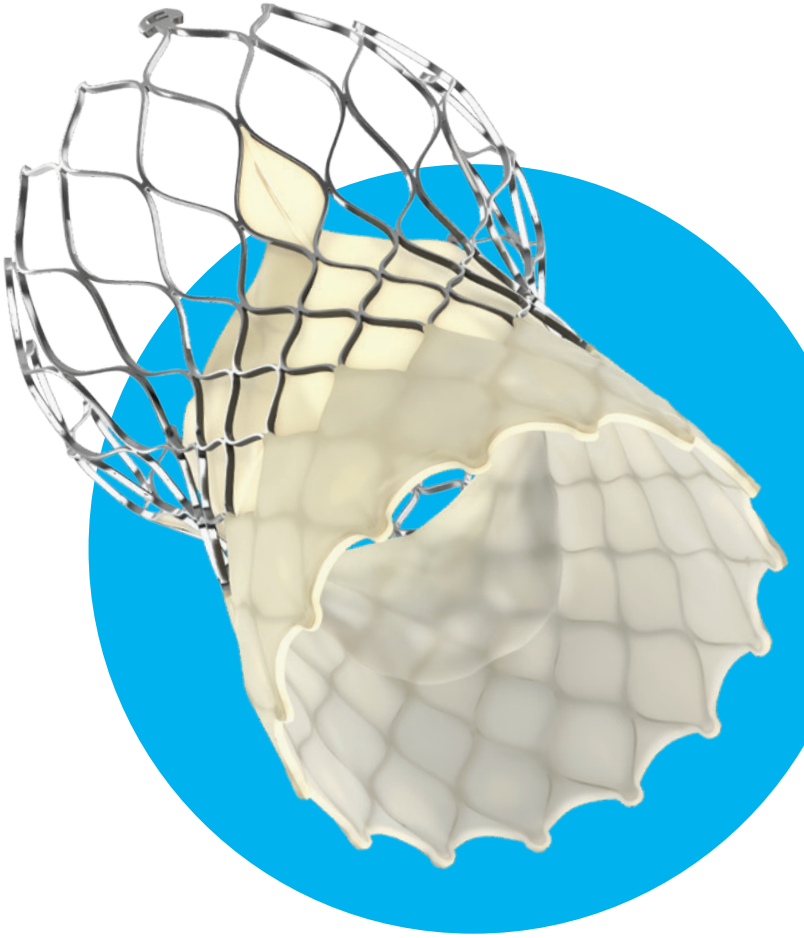

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Reference

1. Reardon M. 5-Year Incidence, Timing and Predictors of Structural Valve Deterioration of Transcatheter and Surgical Aortic Bioprostheses. Presented at ACC 2022.

For healthcare professionals only

Keynote Lecture

Date: 4 December 2022
Time: 14:30-15:15
Moderators: Dr. Gary SH CHEUNG, Dr. Vincent NH LUK

My 20-year journey of TAVI

Prof. Lars SØNDERGAARD

Consultant Cardiologist, Rigshospitalet, Copenhagen
Professor of Cardiology, University of Copenhagen
Denmark

Graduate in 1988 from University of Copenhagen. Trained in cardiology at Rigshospitalet in Copenhagen, as well as Great Ormond Street Hospital for Sick Children and The Heart Hospital in London. Special interest in congenital and structural heart diseases, particular interventional procedures. Led the first-in-human transcatheter mitral valve replacement in 2012. Furthermore, first-in-human implantation for the Gore Septal Occluder for device closure of ASD and PFO (WL Gore & Ass.) in 2011, Inter Atrial Septal Device (Corvia) for HFpEF in 2012, Hydra transcatheter aortic valve bioprosthesis (Vascular Innovations) in 2013, Lotus transcatheter aortic valve DepthGuard system (Boston Scientific) in 2016, and Omega (Eclipse Medical) for left atrial appendage closure in 2019.

Professor of Cardiology at University of Copenhagen since 2015. His thesis *'Quantitative assessment of aortic regurgitation and stenosis using magnetic resonance velocity mapping: Technical aspects and clinical evaluation'* was awarded with a DMSc degree from University of Copenhagen. Published 410 peer reviewed articles, and 16 text book chapters. Principal supervisor for 12 PhD theses. His research interests are focused on adults with congenital heart diseases and catheter-based heart valve interventions. Lead principal investigator for several randomized clinical trials including the TEMPO trial (Bosentan in patients with univentricular hearts palliated with Fontan circulation), the NOTION-1 and NOTION-2 trials (investigating the role of transcatheter aortic valve implantation in younger, lower risk patients with aortic stenosis), NOTION-3 randomised trial (coronary re-vascularization before TAVI), the REDUCE randomised trial (PFO vs anti-platelet therapy after cryptogenic stroke), and the GALILEO 4D trial (effect of anti-coagulation versus anti-platelet on subclinical leaflet thrombosis after TAVI). Deputy editor for EuroIntervention, guest editor for JACC Cardiovascular Intervention, and associated editor for International Journal of Cardiology Congenital Heart Disease.

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† Statistical testing performed outside hierarchy; therefore not considered statistically significant.

‡ Primary composite endpoint of death from coronary heart disease, nonfatal myocardial infarction, fatal or nonfatal ischaemic stroke, or unstable angina requiring hospitalization.

§ Major secondary end points (HR, 95% CI). In order of hierarchical testing, include any coronary heart disease event (0.88, 0.81-0.95), major coronary heart disease event (0.88, 0.80-0.96), any cardiovascular event (0.87, 0.81-0.94), composite of death from any cause, nonfatal myocardial infarction, or nonfatal ischemic stroke (0.86, 0.79-0.93), death from coronary heart disease (0.82, 0.74-1.), the hierarchical analysis was stopped after the first nonsignificant P value was observed, in accordance with the hierarchical testing plan), death from cardiovascular causes (0.88, 0.74-1.05) and death from any cause (0.95, 0.73-0.98). To adjust for multiplicity, the results of the main secondary end points were to be tested in hierarchical fashion in the sequence listed above if the risk of the composite primary end point was found to be significantly lower in the alirocumab group than in the placebo group.

Study Design[2]:
ODYSSEY OUTCOMES is a multicenter, randomized, double-blind, placebo-controlled trial involving 18,924 patients who had an acute coronary syndrome 1 to 12 months earlier, had a low-density lipoprotein (LDL) cholesterol level of at least 70 mg per deciliter (1.8 mmol per liter), a non–high-density lipoprotein cholesterol level of at least 100 mg per deciliter (2.6 mmol per liter), or an apolipoprotein B level of at least 80 mg per deciliter, and were receiving statin therapy at a high-intensity dose or at the maximum tolerated dose. Patients were randomly assigned to receive alirocumab subcutaneously at a dose of 75 mg (9,462 patients) or matching placebo (9,462 patients) every 2 weeks. The dose of alirocumab was adjusted under blinded conditions to target an LDL cholesterol level of 25 to 50 mg per deciliter (0.6 to 1.3 mmol per liter).

MACE=major adverse cardiovascular events. MI=myocardial infarction. UA=unstable angina. PCSK9=Proprotein convertase subtilisin/kexin type 9. CVD=cardiovascular disease. HeFH=Heterozygous Familial Hypercholesterolemia.

References:
1. Praluent® Prescribing information. Mar 2020. 2. Schwartz GG, et al. N Engl J Med. 2018;379:2097-2107.

Presentation: Alirocumab solution for injection. Indications: Prevention of cardiovascular events: Reduce risk of myocardial infarction, stroke and unstable angina requiring hospitalization in adults with established cardiovascular disease. Primary hyperlipidemia (incl. heterozygous familial hypercholesterolemia): As an adjunct to diet, alone or in combination with other lipid-lowering therapies, for the treatment of adults with primary hyperlipidemia to reduce LDL-C. Dosage: 75 mg once every 2 weeks administered subcutaneously. An alternative starting dosage for patients who prefer less frequent dosing is 300 mg once every 4 weeks. If the LDL-C response is inadequate, the dosage may be increased to the maximum dosage of 150 mg administered every 2 weeks. Contraindications: History of serious hypersensitivity reaction to alirocumab. Precautions: Hypersensitivity reactions, Pregnancy and Lactation: There are no available data on use of alirocumab in pregnant women to inform a drug-associated risk. There is no information regarding the presence of alirocumab in human milk, the effects on the breastfed infant, or the effects on milk production. Undesirable effects: Nasopharyngitis, injection site reactions, influenza, urinary tract infection, diarrhea, bronchitis, myalgia, muscle spasms, sinusitis, cough, contusion, musculoskeletal pain, flu-like illness, angioedema. For other undesirable effects, please refer to the full prescribing information. Precaution: 1 x 75mg/ml prefilled pen, 1 x 150mg/ml prefilled pen. Legal Classification: Part 1, First & Third Schedules Poison Full prescribing information is available upon request.
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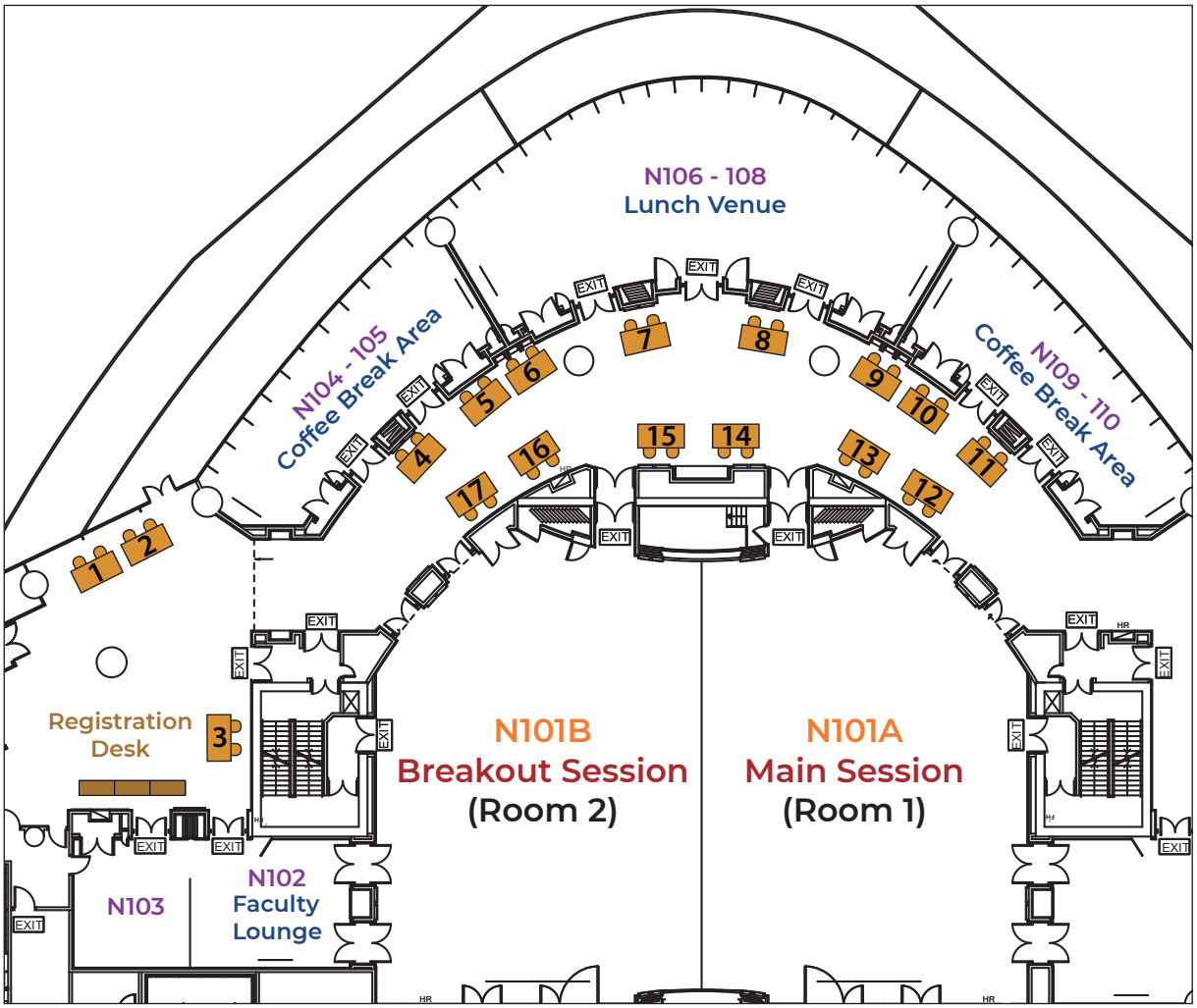
sanofi Sanofi Hong Kong Limited
1/F & Section 212 on 2/F, AXA SOUTHSIDE,
38 WONG CHUK HANG ROAD, WONG CHUK HANG, HONG KONG
http://www.sanofi.hk/

Praluent® alirocumab

Exhibition and Floor Plan

Venue: Meeting Rooms N101 – 112, 1/F, Hong Kong Convention and Exhibition Centre



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Choices with CV benefits:
All-cause mortality reduction

metformin hydrochloride
Glucophage® XR

The UK Prospective Diabetes Study (UKPDS)[1]

The protective effect of metformin on CV outcomes is compared with conventional diet control in overweight patients with newly diagnosed diabetes:

- ↓36% incidence of all-cause mortality (p=0.01)
- ↓39% myocardial infarction (p=0.01)
- ↓30% composite macrovascular disease endpoint (p=0.02)

-36%
in overweight patients with newly diagnosed diabetes[1]

Concor®
Bisoprolol fumarate

Cardiac Insufficiency Bisoprolol Studies (CIBIS-II)[2]

Bisoprolol increases survival rate for NYHA III-IV patients, on top of standard therapy (diuretic + ACE inhibitor):

- ↓34% all-cause mortality (p<0.0001)
- ↓44% sudden death (p=0.0011)
- ↓20% all-cause hospital admissions (p=0.0006)
- ↓36% hospital admission for worsening heart failure (p<0.0001)

-34%
in chronic heart failure patients[2]

References: 1. UKPDS Research Group Lancet, 1998; 352:854-865; 2. CIBIS-II Investigators and Committees (1999) The Lancet;353:9-13.

Products: Concor 2.5mg, Concor 5mg film-coated tablets for oral use containing 2.5mg & 5mg bisoprolol fumarate, respectively. Indications: Concor® 5: Treatment of hypertension, coronary heart disease (angina pectoris), stable chronic heart failure (CHF) with reduced left ventricular systolic function in addition to ACE inhibitors, and diuretics, and optionally cardiac glycosides. Concor 2.5®: Treatment of stable chronic heart failure (CHF) with reduced left ventricular systolic function in addition to ACE inhibitors, and diuretics, and optionally cardiac glycosides. Posology: for hypertension or angina pectoris the dosage is 5mg bisoprolol fumarate once daily which may be increased to 10mg once daily if necessary. Maximum recommended dose is 20mg once daily. Treatment of stable CHF requires a titration phase, starting with a low dose (1.25mg once daily) and with gradual up-titration (2.5, 3.75, 5, 7.5, 10mg once daily at weekly consideration basis) according to tolerability. Maximum recommended dose for CHF is 10mg bisoprolol fumarate once daily. Special populations: In severe renal impairment (creatinine clearance <20ml/min) or severe liver function disorders a daily dose of 10mg bisoprolol fumarate should not be exceeded for treatment of hypertension of angina pectoris and dose titration in patients with these functional impairments for CHF should be made with particular caution. Use in children is not recommended. Treatment with bisoprolol must not be stopped abruptly, since this might lead to a transitory worsening of heart condition. If transient worsening of heart failure, hypotension or bradycardia occurs during or thereafter the titration phrase, recommend to reconsider the dosage of concomitant medication, or temporarily lower the dose of bisoprolol, or discontinuation. Reintroduction and/or, up titration of bisoprolol should always be considered when patient becomes stable again. Contraindications: acute heart failure or during episodes of heart failure decompensation, cardiogenic shock, second or third degree AV block, sick sinus syndrome, sinoatrial block, symptomatic bradycardia or hypotension, severe bronchial asthma, severe forms of peripheral arterial occlusive disease or severe forms of Raynaud's syndrome, untreated phaeochromocytoma, metabolic acidosis, hypersensitivity to bisoprolol or to any of the excipients. Warnings and precautions for use: Use with caution in: bronchospasm (bronchial asthma, obstructive airways disease; concomitant bronchodilating therapy recommended); diabetes mellitus; symptoms of hypoglycemia can be masked; strict fasting; ongoing desensitization therapy; first degree AV block; Prinzmetal's angina; peripheral arterial occlusive disease; allergic reactions; phaeochromocytoma. Patients with psoriasis or with a history of psoriasis should only be given beta-blockers (e.g. bisoprolol) after a careful balancing of benefits and risks. Symptoms of thyrotoxicosis may be masked. In patients undergoing general anesthesia, the anaesthetist must be aware of beta-blockade. If it is thought necessary to withdraw beta-blocker therapy before surgery, this should be gradually and completed about 48 hours before anesthesia. Initiation of treatment of stable chronic heart failure with bisoprolol necessitates regular monitoring. There is no therapeutic experience in Concor in patients with Class II heart failure and concomitant insulin dependent type I diabetes mellitus, severely impaired kidney function, severely impaired hepatic function, restrictive cardiomyopathy, congenital heart disease, hemodynamically significant organic valvular disease. Age>80 years, myocardial infarction within 3 months. Ability to drive and use machines: may be impaired, particularly at start of treatment, upon change of medication, or in conjunction with alcohol. Interactions: Combinations not recommended: class I antiarrhythmic drugs (CHF), calcium antagonists of the verapamil and diltiazem type, centrally-acting antihypertensive drugs. Combinations to be used with caution: class I antiarrhythmic drugs (hypertension or angina pectoris), calcium antagonists of the dihydropyridine type, class III antiarrhythmic drugs, parasympathomimetic drugs, topical beta-blockers (e.g. eye drops), insulin and oral antidiabetic drugs, anesthetic agents, digitalis glycosides, non-steroidal anti-inflammatory drugs (NSAIDs), sympathomimetic agents, antihypertensive agents and other drugs with blood pressure lowering potential. Combination to be considered: mefloquine, monoamine oxidase inhibitors. Pregnancy and lactation: Use of bisoprolol not recommended. Adverse reactions: Very common: bradycardia (in CHF patients). Common: worsening of pre-existing heart failure (in CHF patients), dizziness, headache, gastrointestinal complaints such as nausea, vomiting, diarrhea, constipation; feeling of coldness or numbness in the extremities, hypotension, asthenia (in CHF patients), fatigue. Uncommon: AV-conduction disturbances, bronchospasm in patients with bronchial asthma or a history of obstructive airway disease, muscle weakness, muscle cramps, orthostatic hypotension, depression, sleep disorders; in patients with hypertension or angina pectoris: worsening of pre-existing heart failure, bradycardia, asthenia. Rare: increased triglycerides, increased liver enzymes (ALAT, ASAT) syncope, reduced tear flow, hearing disorders, allergic rhinitis, hypersensitivity reactions such as itching, flush, rash; hepatitis, potency disorders, nightmares, hallucinations. Very rare: conjunctivitis, alopecia; beta-blockers may provoke or worsen psoriasis or include psoriasis-like rash. Most common signs of overdose: bradycardia, hypotension, bronchospasm, acute cardiac failure, hypoglycemia. Date of product information: July 2016

Contents: Metformin HCl Indications: Reduction in risk or delay onset of type 2 DM in adult, overweight patients with IGT and/or IFG, and/or increased HbA1C who are at high risk for developing overt type 2 DM and still progressing towards type 2 DM despite implement intensive lifestyle change for 3 - 6 months. Treatment of type 2 DM in adults as an adjunct to adequate diet & exercise. Monotherapy or in combination w/ other oral antidiabetic medicines or insulin. Dosage: Adult w/ normal renal function (GFR ≥90 mL/min) Reduction in the risk or delay of the onset of type 2 DM Initially one 500-mg tab once daily w/ evening meal. After 10-15 days, adjust dose based on blood glucose measurements. Max: 2,000 mg once daily. Monotherapy in type 2 DM & combination w/ other oral antidiabetics agents Usual starting dose: One 500-mg tab once daily, or one 1,000-mg tab once daily. After 10-15 days, adjust dose based on blood glucose measurements. Max. recommended dose for 500 mg and 1g tab is 2g daily. Max. recommended dose for 750 mg tab is 1.5g daily. Combination with insulin Usual starting dose is one tablet XR 500 mg or XR 1 g once daily, while insulin dosage is adjusted on the basis of blood glucose measurements. For renal impairment patients A GFR should be assessed before initiation of treatment and at least annually thereafter. In patients at an increased risk of further progression of renal impairment and in the elderly, renal function should be assessed more frequently, e.g., every 3 - 6 months. Total max. daily dose of 2 g for GFR 60 - 89 mL/min, consider dose reduction for declining renal function. Total max. daily dose of 2 g for GFR 45 - 59 mL/min, review any increased risk of lactic acidosis before initiating metformin, whereas starting dose is at most half of max. dose. Total max. daily dose of 1 g for GFR 30 - 44 mL/min, review any increased risk of lactic acidosis before initiating metformin, whereas starting dose is at most half of max. dose. Pre- & Post-Prandial Advice: Swallow whole, do not chew/crush. Contraindications: Any type of acute metabolic acidosis (such as lactic acidosis, diabetic ketoacidosis), severe renal failure (GFR < 30mL/min), hepatic insufficiency, infectious diseases, following an IV urography or angiography, heart failure, recent MI, resp. failure, shock, persistent or severe diarrhoea, recurrent vomiting, alcoholism. Lactation. Special Precautions: Regular renal & blood sugar monitoring. Risk of lactic acidosis, most often occurs at acute worsening of renal function or cardiorespiratory illness or sepsis. Discontinue prior administration of iodinated contrast agents or surgery. May impair ability to drive or operate machinery in combination w/ other antidiabetic agents. Pregnancy. Elderly (for reduction of risk or delay of type 2 DM) Interactions: Iodinated contrast agents, corticosteroids, NSAIDs, ACE inhibitors, diuretics, sympathomimetics, alcohol, COX II inhibitors, angiotensin II receptor antagonists, OCT1 and OCT2 inhibitor/ inducer Presentations: XR tab 500 mg x 60's. 750 mg x 30's. 1,000 mg x 60's. Date of version: JUN 2018

Merck Pharmaceutical (HK) Limited
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HK-MULCMC-00028 JUL2022

Symposium Information

Organizer
Hong Kong Society of Congenital & Structural Heart Disease (HKCASH)

Symposium Venue
Meeting Rooms N101–112, 1/F, Hong Kong Convention and Exhibition Centre
Address: 1 Expo Drive, Wan Chai, Hong Kong

Registration	**N100 Concourse**
Coffee/Tea	**N104-105, N109-110**
Main Session	**N101A**
Breakout Session	**N101B**
Lunch	**N106-108**

Faculty Lounge
N102, Level 1 (for Invited Speakers, Moderators and Panelists only)

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No photo taking, audio recording and video shooting are allowed in the meeting rooms unless permission is granted.

Virtual Symposium Login Instruction
Virtual participants will receive a login link by email closer to the Symposium to access the Virtual Platform.

Certificate of Attendance
Evaluation will be sent to all attendees after the Symposium, on or before 9 December 2022. E-Certificate of Attendance will be sent by email to those who have completed the evaluation.

Official Language
English

Secretariat
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2. For CNE Accreditation, please complete and return the Evaluation Survey which will be sent to you within 5 days after the Symposium. Your attendance will be sent to the Hong Kong Cardiac Nursing Association (HKCNA) upon the completion of the Evaluation Form. The Certificate of attendance with CNE accreditation will be sent to you via email in due course. Online attendance must be more than 80% of total duration of the event.

3. The final accreditation will be at the discretion of individual college / association. The Secretariat will send your attendance to the listed Colleges you specified on the registration form.

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Please see our website at www.apcash.org/accreditation.html for more details.

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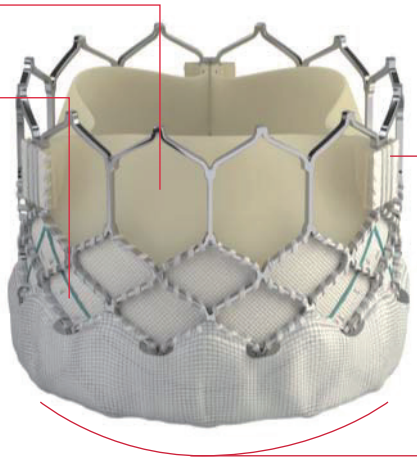

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