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Message from the President

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President, Hong Kong Institute of Allergy

Dear esteemed colleagues, partners, and friends of the Hong Kong Institute of Allergy,

As the newly elected President, it is with a sense of great honour and personal significance that I proudly welcome you to a new chapter in our journey. HKIA is not just an institute or society for me, it's a cherished community that holds a special place in my heart. I started as one of the first Immunology & Allergy trainees supervised by the late Prof Tak Lee. With the support of an HKIA scholarship, I was able to complete my overseas training. Now, I am filled with immense pride and gratitude as I represent the HKIA on various international platforms, and being recognized as part of HKIA is a distinct honour that I deeply cherish.

HKIA, as the representative professional society, has been instrumental in shaping the development of allergy and immunology in Hong Kong, a testament to the collective dedication and expertise of our community. During my tenure, I will pay homage to our legacy and past successes, embrace and capitalize on current opportunities, and strategically pave the way for a sustainable future.

In recent years, HKIA has achieved significant milestones, a testament to our collective efforts. We have successfully advocated for Higher Physician Training for Immunology & Allergy, thereby elevating local allergy standards. Our consensus statements, such as the COVID-19 Vaccine Allergy Safety, have directly influenced public health policies, including the Department of Health's vaccination programmes.

We take great pride in our flagship allergy conventions and eagerly anticipate the upcoming EAACI Allergy School, which will be hosted in Hong Kong. These platforms not only inspire knowledge exchange but also solidify our position on the international stage.

As we embark on this new chapter, our commitment to building on the strong foundation laid by our predecessors remains steadfast. We will continue to support training and professional development, focusing particularly on new and upcoming specialist trainees and young doctors. Our commitment to improving local and regional allergy care through ongoing initiatives and collaborations across multiple disciplines remains unwavering.

In our pursuit of excellence, we will strive to further our influence and forge stronger partnerships, both locally and internationally. Our continued collaboration with the Greater Bay Area and various international societies underlines this commitment.

Together, let us continue to shape the future of allergy and immunology in Hong Kong and beyond. Our collective efforts will ensure HKIA's legacy as a leading institution in allergy and immunology.

Dr. Philip Li
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Message from the Editor

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Dear Colleagues and Readers,

As we embrace the renewal of spring, the Hong Kong Institute of Allergy is delighted to present our Spring 2025 e-Newsletter, featuring cutting-edge insights from three distinguished contributors. This edition highlights the interdisciplinary collaboration essential to advancing allergy care, bridging clinical practice, research, and patient-centered approaches.

Exploring the Microbiome's Role in Allergy and Rhinosinusitis

Opening this issue, Dr. David Yeung (ENT) delves into the fascinating interplay between the microbiome and allergic diseases. His article "The Role of the Microbiome in Allergic Rhinitis and Chronic Rhinosinusitis" examines how microbial communities influence immune responses and disease progression. This timely discussion underscores the potential for microbiome-targeted therapies to revolutionize treatment paradigms—a must-read for clinicians seeking to integrate emerging science into practice.

Understanding Ocular Sequelae of Stevens-Johnson Syndrome

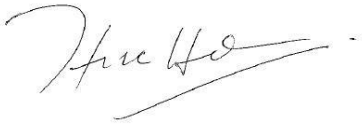
Dr. K.W. Kam, Dr. Victor Tsun-Tat Chan and Mr. Alvin Tsang (Ophthalmology) contributes a critical review titled "Acute and Chronic Ocular Sequelae of Stevens-Johnson Syndrome" shedding light on the long-term visual complications of this severe condition. His work emphasizes early intervention and multidisciplinary management to mitigate irreversible damage, offering actionable strategies for ophthalmologists and allergists alike.

Addressing Secondary Antibody Deficiency: Challenges and Progress

New to this edition, Dr. Andy Kan and Dr. Philip Li (Immunology) explores a pivotal topic in his article" Secondary Antibody Deficiency: Disparities in Diagnosis and Treatment, and a Ray of Hope from Standardised Management." Dr. Kan addresses the diagnostic and therapeutic gaps in managing secondary antibody deficiencies, advocating for standardized protocols to improve patient outcomes. His analysis balances clinical challenges with optimism, highlighting advancements that promise to bridge existing disparities.

We extend our sincere gratitude to Dr. Yeung, Dr. Kam, Dr. Chan, Mr. Tsang, Dr. Kan and Dr. Li for their expertise and dedication. Their contributions reflect the HKIA's commitment to fostering knowledge exchange across specialties.

To our readers, we hope this edition inspires fresh perspectives and enriches your practice. As always, we welcome your feedback and encourage submissions for future issues. Together, let's continue advancing allergy care through collaboration and innovation.



Dr. Marco H.K. Ho
Editor, HKIA e-newsletter
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Stay curious, stay informed.

The Role of the Microbiome in Allergic Rhinitis and Chronic Rhinosinusitis

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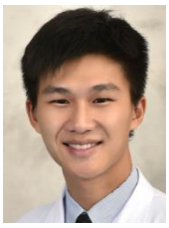

Allergy affects a significant portion of the global population, particularly children and adolescents. Its manifestation in rhinology is allergic rhinitis (AR), with diagnosis heavily reliant on history and clinical examination, supplemented by allergen-specific testing methods such as skin prick tests or serum assessments. Treatment options for AR include oral antihistamines, intranasal corticosteroids, leukotriene receptor antagonists, and immunotherapy. Despite these interventions, many patients experience incomplete symptom relief and recurrent episodes, underscoring the need for alternative or complementary therapeutic strategies to manage this burdensome condition.

The nasal cavity, a vital component of the upper respiratory tract, serves as a primary interface between the external environment and the host. It is lined with a diverse microbial community, or normal flora, which plays an essential role in maintaining mucosal health and immune homeostasis. This microbiota consists of various bacterial genera, including *Moraxella*, *Corynebacterium*, *Staphylococcus*, and *Dolosigranulum*. These commensal microorganisms help maintain a balanced microenvironment by competing with potential pathogens, modulating immune responses, and contributing to the structural integrity of the mucosal barrier. A healthy and diverse nasal microbiota supports immune regulation by promoting the differentiation of regulatory T cells (T-regs) and the production of anti-inflammatory cytokines such as IL-10.

Disruptions in this delicate microbial ecosystem, known as dysbiosis, have been implicated in the pathogenesis of AR and other nasal inflammatory conditions. Recent research has highlighted the potential role of the nasal microbiome in the development and progression of AR. Dysbiosis in the nasal mucosa is thought to influence the type and intensity of immune responses to allergens, skewing these responses to drive the recruitment and activation of eosinophils, mast cells, and other immune cells, leading to the hallmark symptoms of AR.

The composition of the nasal microbiome is established early in life and is influenced by factors such as mode of delivery, feeding practices, environmental exposures, and antibiotic use. Early microbial colonization of the nasal mucosa is thought to have long-lasting effects on immune development and susceptibility to allergic diseases. For instance, the presence of certain bacterial genera, such as *Moraxella* and *Streptococcus*, in the nasal cavity of infants has been associated with a reduced risk of developing AR and other respiratory conditions later in life. Conversely, disruptions in the establishment of a healthy microbiota, such as those caused by cesarean delivery or early antibiotic exposure, may increase the risk of allergic sensitization and chronic inflammation. This underscores the importance of understanding the factors that shape the nasal microbiome during critical periods of immune development.

The interplay between the host immune system and the nasal microbiome is complex and not fully understood, but it represents a promising area of exploration for novel therapeutic approaches such as the use of probiotics, prebiotics, and other microbiome-targeted interventions.

Allergy also has a bearing on rhinosinusitis. Central compartment atopic disease (CCAD) is a relatively recently described phenotype of chronic rhinosinusitis with nasal polyposis (CRSwNP). It is distinguished by central compartment involvement, including polypoid changes or inflammation in the middle turbinate (MT), superior turbinate (ST), and posterosuperior nasal septum (PSNS). First introduced by DelGaudio et al., CCAD is increasingly recognized as a distinct subset of CRSwNP strongly associated with inhalant allergies. The condition is characterized by a type 2 inflammatory

endotype, marked by elevated levels of interleukin-5 (IL-5) and IL-13, as well as eosinophilic inflammation. These immune responses are thought to be driven by aeroallergen exposure, triggering local and systemic allergic reactions.

A strong correlation between CCAD and AR has been consistently reported across various studies. Patients with CCAD typically exhibit a high prevalence of atopy, with allergen sensitization rates ranging from 73% to 100% in studies conducted in Western populations. For instance, Hamizan et al. found that CCAD was associated with significantly higher rates of inhalant allergen sensitization compared to other CRSwNP subtypes, supporting the role of allergy as a key driver in its pathophysiology. Similarly, Marcus et al. observed that CCAD patients had a high prevalence of inhalant allergen sensitization but a relatively low prevalence of asthma compared to other CRSwNP phenotypes. This unique clinical profile suggests that CCAD may be primarily mediated by upper airway allergic responses, with less involvement of the lower respiratory tract.

In East Asian populations, such as those in China and Taiwan, the association between CCAD and allergy appears to be less pronounced. Nie et al. reported that only 37.1% of CCAD patients in Southern China demonstrated systemic allergen sensitization based on skin and serum testing, a markedly lower prevalence than observed in Western cohorts. Despite this, CCAD in Chinese patients was still characterized by eosinophilic inflammation, with tissue eosinophil counts significantly higher than those in other CRSwNP subtypes. This suggests that while allergy may play a role in CCAD, other factors, such as regional or genetic influences, may modulate its pathogenesis in different populations.

The role of the microbiome in CCAD has not been extensively studied, but emerging evidence suggests that it may contribute to shaping the inflammatory environment of the central compartment. The nasal microbiome, composed of commensal and potentially pathogenic bacteria, influences mucosal immunity and may interact with allergens to exacerbate or mitigate type 2 inflammation. A better understanding of these interactions could provide new insights into CCAD pathophysiology.

In conclusion, understanding the interplay between the microbiome, aeroallergens, and host immune responses could pave the way for innovative therapies. Strain-specific probiotics and microbiome-modulating interventions may complement existing treatments like corticosteroids, immunotherapy, and biologics. These microbiome-focused approaches hold promise in improving disease control and outcomes for patients with AR, CCAD, and other allergy-associated disorders. The nasal microbiome represents a promising frontier in allergy research, with the potential to enhance the quality of life for affected individuals.

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Acute and Chronic Ocular Sequelae of Stevens-Johnson Syndrome and the Role of Amniotic Membrane Transplant

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Introduction

Stevens-Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN) encompass a spectrum of rare, yet life-threatening immune-mediated hypersensitive reactions that result in extensive damage to the skin and mucous membranes.

Individuals carrying unique genetic markers, such as the HLA-B*1502 alleles are at a higher risk of developing SJS/TEN, especially when exposed to certain medications [4]. SJS/ TEN is usually drug-induced and the most commonly implicated medications include anticonvulsants, antibiotics, oxicam non-steroidal anti-inflammatory drugs, and allopurinol [3]. Although uncommon, SJS/ TEN is associated with substantial morbidity and mortality, with an overall mortality rate of 21.6% in our local population [2].

Ocular Manifestations of SJS/TEN

The ocular surface is frequently involved in SJS/TEN and its manifestation can be divided into acute and chronic phases. The acute phase manifestations range from self-limited conjunctival hyperemia, to eyelid margin sloughing, pseudomembrane formation, conjunctival and corneal epithelial defects, or even corneal perforation. Patients with ocular involvement often progress to develop chronic ocular sequelae in at least one-third of cases [1]. These chronic sequelae are results of inflammation and scarring leading to the disruption of the architecture and homeostasis of the ocular surface. In the subacute and chronic phase, inflammation may result in the formation of symblepharon and ankyloblepharon, conjunctival scarring, meibomian gland dysfunction, tear deficiency, punctal occlusion or limbal stem cell deficiency (LSCD) [6].

Given the potential blinding complications of SJS/TEN, ophthalmologists should be involved in the early evaluation and treatment of SJS/ TEN. While conventional medical therapies include intensive lubricants and topical corticosteroid eyedrop, it has also been suggested that amniotic membrane transplantation (AMT) is effective in preventing chronic ocular complications. The first reported use of AMT in SJS was in 2002. Despite subsequent case reports, the first

randomized controlled trial was published in 2016, which provides a high level of evidence to support the role of AMT in maintaining a stable ocular surface and preventing subsequent scarring. In this article, we included a case series of SJS/TEN from our centre to discuss the role of AMT in SJS/ TEN [5].

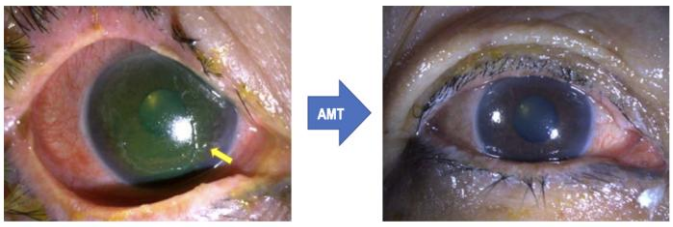
Methodology of the Investigations on AMT and Its Effectiveness on SJS/TEN

We retrospectively reviewed the clinical records of patients diagnosed with acute SJS/TEN who received ophthalmic consultation for suspected ocular involvement at the Prince of Wales Hospital between 2019 to 2021. Subjects with unstable vitals or inability to cooperate with ophthalmic examinations were excluded.

All patients underwent a complete ophthalmic assessment to determine the severity of ocular involvement. Acute severity was assessed using Sotozono's grading system, evaluating conjunctival hyperemia, ocular surface epithelial defects and pseudomembrane formations. For those who underwent AMT, chronic ocular manifestations were also assessed based on Sotozono's chronic stage grading, which includes corneal, conjunctival and eyelid complications [9]. Between-group differences were compared by generalized linear mixed equations to adjust for inter-eye correlation.

Results

11 patients received ophthalmic consultation for suspected ocular involvement in SJS/TEN, including 4 patients with SJS and 7 patients with TEN. The severity of ocular involvement was similar between SJS and TEN during the acute phase. Twelve eyes of 7 patients received AMT, with a median time of 8 days after the onset of first ocular symptom. The ocular surface involvement was worse among eyes requiring AMT in terms of Sotozono scores (2.50 vs 1.59, p=0.0294). In eyes requiring AMT, the most common ocular manifestations include conjunctival hyperemia (100%), lid margin inflammation (83.3%), pseudomembrane formation (50%), conjunctival defect (50%) and corneal epithelial defect (75%).



#11 YYH OD
Pre-op

#11 YYH OD
Post-op Day 12

The image above illustrates the effect of AMT in promoting cornea healing in the acute phase. Before AMT, there was a 70% corneal epithelial defect, with significant conjunctival hyperaemia. After AMT, the epithelial defect was healed, with a marked reduction in conjunctival hyperaemia.

Long-term outcomes of AMT

Regarding the chronic sequelae, the most common corneal complication is superficial punctate keratopathy (7 eyes). Most eyes achieved a good visual prognosis without severe corneal complications, except for one eye which developed necrosis of stroma despite AMT and required a tectonic corneal transplant.

Regarding the conjunctival and eyelid complications, conjunctival hyperaemia (6 eyes) and meibomian gland dysfunction (5 eyes) were the most common. Trichiasis (1 eye) and disruption of mucocutaneous junction (1 eye) were also observed. In addition, two eyes were found to have persistent superior limbic keratoconjunctivitis during subsequent visits.

Challenges of Applying Amniotic Membrane Transplantation

Despite the apparent benefits of AMT in SJS/ TEN, challenges exist in actual clinical practice. Firstly, expertise is required to perform AMT, with special surgical techniques to cover the bulbar and palpebral conjunctiva with the amniotic membrane. Secondly, the amniotic membrane might obscure vision as well as ophthalmic examination during the early post-operative period. Thirdly, repeated AMT might be required as amniotic membranes are prone to dissolution and dislodgement with time. Fourth, the involvement of ophthalmologists in SJS/TEN is often delayed due to insufficient awareness of its ocular manifestation, which might reduce the effectiveness of AMT. Finally, the production of AM is not standardized. For example there are different forms of amniotic membrane, including

both dry and cryopreserved amniotic membrane, along with different techniques of applications [7,8].

Conclusions

In conclusion, the ocular surface is frequently involved in both the acute and chronic phases of SJS/TEN. Early AMT in the acute phase is effective in stabilizing the ocular surface and should be considered in SJS/TEN subjects with severe ocular involvement. Timely ophthalmic consultation and interventions are warranted in all cases of SJS/TEN to reduce ophthalmic morbidity, and prevent chronic ocular sequelae and blinding complications.

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Secondary Antibody Deficiency: Disparities in Diagnosis and Treatment, and a Ray of Hope from Standardised Management

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Introduction

Immunodeficiencies, often referred to as inborn errors of immunity, are frequently under-recognised, particularly in adults, despite imposing a significant burden on health and healthcare systems. The most prevalent type of these immunodeficiencies is antibody deficiencies, which represent approximately 40% of cases in adult patients in Hong Kong.(1) Antibody deficiencies can be categorised based on their cause into primary and secondary forms. Primary antibody deficiencies are genetic disorders resulting from inherited mutations, while secondary antibody deficiencies develop as a consequence of other medical conditions or treatments, including drug-induced hypogammaglobulinemia (such as from immunosuppressants, chemotherapy, biologics, or anti-epileptic medications), autoimmune diseases, haematological malignancies, and protein-losing states.(2)

While primary antibody deficiency is estimated to affect approximately 320,000 individuals globally – secondary antibody deficiency is thought to be roughly 30 times more common.(2) Our team's study in Queen Mary Hospital, a tertiary and quaternary referral centre in Hong Kong, indicate that over 95% of patients receiving immunoglobulin replacement therapy have secondary antibody deficiency, while less than 5% suffer from primary antibody deficiency.(1) This growing recognition underscores the importance of understanding the epidemiology, diagnosis, and treatment of secondary antibody deficiency, particularly in light of its substantial burden on healthcare systems worldwide.

Disparities in diagnosis of secondary antibody deficiency

One of the key challenges in managing secondary antibody deficiency is its underdiagnosis. Many individuals with secondary antibody deficiency may present as asymptomatic despite having significant immunoglobulin deficiencies or antibody responses. Prompt diagnosis, preferably through screening (e.g. with an immunoglobulin profile [IgG, IgA, IgM]) of at-risk populations – such as those with haematological malignancies or those undergoing treatment with immunosuppressants – is crucial in preventing serious infections.(3) However, systematic screening practices are not routinely employed, and patients often go undiagnosed until they develop severe infections.

Several factors contribute to this diagnostic gap. First, patients with underlying diseases are typically managed by various specialties that may not prioritise screening for secondary antibody deficiency, especially among non-immunologist clinicians who may lack sufficient awareness.(4, 5) Second, the absence of global consensus on screening guidelines and the inconsistent integration of secondary antibody deficiency protocols in existing disease-specific guidelines exacerbate the problem. For example, some guidelines recommend

checking immunoglobulin profiles regularly (e.g. at diagnosis and every four to six months),(3, 6, 7) while others do not stipulate any follow-up monitoring after initial diagnosis.(8-11) Lastly, disparities in the availability of immunology services across countries, especially in the Asia-Pacific region (including Hong Kong) where immunologists are scarce, contribute to the underdiagnosis of secondary antibody deficiency.(12)

Disparities in treatment of secondary antibody deficiency

Treatment for secondary antibody deficiency are fraught with disparities due to a lack of standardised guidelines. Treatment is often determined by individual clinical judgment rather than consistent protocols, leading to variability in approach across different healthcare settings. Notably, while hypogammaglobulinaemia is defined through serum IgG levels – with moderate to severe cases warranting treatment—there is no universal threshold for initiating immunoglobulin replacement therapy. Disease/aetiology-specific guidelines vary widely, with some recommending treatment only in specific scenarios while others suggest more liberal criteria.(9, 13-15)

Moreover, the continuing reliance on expert opinion and limited studies means that many recommendations are not evidence-based. For instance, there are differing disease/aetiology-specific guidelines on immunoglobulin dosing and frequency, with some organisations endorsing monthly treatment while others have unclear recommendations.(8, 16, 17) This lack of clarity can lead to inefficient treatment practices, such as administering immunoglobulin replacement on an 'as needed' basis rather than at regular intervals, which is ineffective in preventing infections.(18-20)

Standardised management of secondary antibody deficiency – a ray of hope

The pressing challenges associated with the diagnosis and treatment of secondary antibody deficiency signal an urgent need for standardised management practices. Efforts to establish a universal framework for the treatment of secondary antibody deficiency have gained traction, with organisations such as the American Academy of Allergy, Asthma, and Immunology (AAAAI) advocating for clear guidelines on immunoglobulin replacement criteria.(3) Recommendations include indications for immunoglobulin therapy based on the patient's clinical history of infections, the assessment of serum immunoglobulin levels, and the evaluation of specific antibody responses. According to the AAAAI,(3) immunoglobulin replacement is indicated in any secondary antibody deficiency patients with:

1) history of severe/persistent/unusual/recurrent (with the mnemonic 'SPUR') infections + IgG level <700 mg/dL + reduced IgM/IgA levels and vaccine response,

2) history of 'SPUR' infections and IgG level <400 mg/dL,

3) history of 'SPUR' infections and having breakthrough infections despite antibiotic prophylaxis, or

4) IgG <150 mg/dL.

For patients with IgG level <700 mg/dL + reduced IgA/IgM and vaccine response, or IgG level <400 mg/dL but no history of 'SPUR' infections, immunoglobulin replacement should be a shared decision between the physician and the patient.

Such a standardised approach aims to reduce the discrepancies in treatment modalities observed across different healthcare settings and provide clinicians with clear guidance on when to initiate immunoglobulin replacement. A framework for shared decision-making for patients who may not exhibit classic indications ensures a more patient-centred approach in managing secondary antibody deficiencies.

In addition to advocating for standardised treatment guidelines, enhancing education and training on secondary antibody deficiency for healthcare providers is paramount. Continuous professional development focusing on the identification, management, and guidelines surrounding secondary antibody deficiencies could bridge knowledge gaps prevalent among non-immunologists. Improved interprofessional communication and collaboration can also foster a more cohesive understanding of secondary antibody deficiency management, ultimately contributing to better patient outcomes.

In parallel, addressing disparities in access to immunological services across regions is crucial.(1, 12, 21) Encouraging the development of immunology training programs and increasing the number of clinical immunologists can enhance the overall diagnostic and treatment capabilities for secondary antibody deficiency. Additionally, establishing clear referral pathways for suspected cases of secondary antibody deficiency will help ensure that patients have timely access to specialised care.

Conclusion

The global epidemiology of secondary antibody deficiency highlights a substantial healthcare challenge ripe for improvement. With its prevalence overshadowing that of primary antibody deficiency and a significant number of cases remaining underdiagnosed, secondary antibody deficiency presents a considerable public health burden. The disparities in diagnosis and treatment underscore the urgent need for a standardised, evidence-based approach to effectively manage this condition. By closing the knowledge gaps among healthcare providers and establishing consistent guidelines, it is possible to improve patient outcomes and enhance the quality of care for individuals suffering from secondary antibody deficiency. Addressing these challenges poses an opportunity for healthcare systems worldwide to recognise and treat this often-overlooked condition decisively.

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HKIA & HKSR Summit: IL-5 in T2 Inflammation – Transforming Care in EGPA

24 February 2025

The Hong Kong Institute of Allergy and the **Hong Kong Society of Rheumatology** jointly hosted a Dinner Summit on "**IL-5 in T2 Inflammation - Transforming Care in EGPA**" on February 24, 2025 (Monday) at the Hyatt Regency in Tsim Sha Tsui.

An exceptional lineup of speakers provided updates on the shared eosinophilic pathways in EGPA and airway diseases, while reviewing the targeted benefits of mepolizumab for both individual and co-morbid conditions.

EAACI Hong Kong Allergy School 2025

27 – 29 August 2025

Dear Esteemed Colleagues and Friends,

On behalf of the **European Academy of Allergy & Clinical Immunology (EAACI)** and **Hong Kong Institute of Allergy (HKIA)**, it is our immense pleasure to extend a warm welcome to each of you as we gather for a groundbreaking milestone in allergy education and global collaboration - the inaugural EAACI Hong Kong Allergy School.

This year marks a historic moment as we proudly host this **first-ever EAACI flagship event outside Europe** - right here in Hong Kong. Nestled at the gateway between Asia and the rest of the world, Hong Kong offers the perfect backdrop for this pioneering partnership between EAACI and China. Together, we unite Eastern and Western expertise under the theme "**East Meets West**", fostering a transformative dialogue that bridges continents. Our distinguished international faculty - renowned experts from across the globe - will share cutting-edge insights spanning the full spectrum of allergy and clinical immunology.

Designed to be inclusive and interdisciplinary, the program also features an additional **dedicated Chinese track** for our Chinese-speaking colleagues, ensuring accessibility while celebrating the diversity of our global community. Participants will also enjoy opportunities to showcase their research through **oral and poster presentations**, engage with leading industry partners, and forge connections with peers from every corner of the world. Prizes will be presented to those selected by our international faculty of allergy experts.

To commemorate this landmark occasion, we are delighted to offer **exclusive benefits**: **a discounted registration rate for current EAACI members** and **a complimentary 1-year EAACI membership for all new registrants**. Join us in building a vibrant global network dedicated to advancing allergy care.

As we embark on this exciting journey together, we encourage you to seize the moment: Submit your abstracts **before the submission deadline on 10 May** and secure your place **with early bird registration discounts that ends on 30 June**!

Your presence will elevate this celebration of collaboration, innovation, and shared knowledge. Let us bridge ideas, inspire breakthroughs, and shape the future of allergy science and practice - together.

With great enthusiasm and anticipation,

Chairpersons, EAACI Hong Kong Allergy School 2025

Dr. Philip Li
Local Organising Committee Chair

Dr. Mohamed Shamji
EAACI Secretary General

Dr. Maria Torres
EAACI President

Co-hosts: EAACI | HONG KONG INSTITUTE OF ALLERGY 香港過敏科醫學會

EAACI Hong Kong Allergy School 2025

East Meets West

27 – 29 August 2025

Hong Kong (LKS Faculty of Medicine, University of Hong Kong)

We cordially invite you to the **EAACI Hong Kong Allergy School 2025** — a groundbreaking milestone in allergy education and global collaboration.

This historic event outside Europe will take place in vibrant Hong Kong, bridging Eastern and Western expertise under the theme "**East Meets West**"

CALL FOR ABSTRACTS!
Contribute your research and insights in medical and allergy!

SUBMIT NOW!

Free registration will be offered for selected oral abstract presenters! (including the EAACI 1-year membership)

REGISTER BEFORE THE EARLY BIRD RATE ENDS ON 30 JUNE!

REGISTER NOW!

INTERNATIONAL FACULTY

Stephen Durham (United Kingdom)
Hiliary Longhurst (New Zealand)
Michihiro Hide (Japan)
Martin Metz (Germany)
Connie Katelaris (Australia)
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David Khan (USA)
Maria Torres (Spain)
Philip Li (Hong Kong)
Jason Trubiano (Australia)
Guang-hui Liu (China)
...and many more!

ENQUIRIES

SECRETARIAT
Tel: (852) 2116 4320 Fax: (852) 2559 6910
Email: enquiry@eaacihk2025.com

Supporting Organizations:

The 13th Hong Kong Allergy Convention 2025
18 – 19 October 2025

The 13th Hong Kong Allergy Convention (HKAC 2025) will be held on **18 – 19 October 2025** at the **Hong Kong Convention and Exhibition Centre (HKCEC)**.

With the theme of "**Allergy Beyond Borders**", this Convention aims to highlight novel discoveries in mechanisms and development of cutting-edge treatment and preventative paradigms for allergic diseases. More than 400 medical practitioners and allied health professionals from related medical disciplines are expected to attend this significant Convention.

SAVE THE DATE: hkac@icc.com.hk